Behavioral

Health

Services

2013

MoHealth Net

MO HealthNet Behavioral Health Billing Book

Preface

This Behavioral Health Services training booklet contains information to help providers submit claims correctly. The booklet is not all-inclusive of program benefits and limitations; providers should refer to specific program manuals for the entire content. Current Procedural Terminology (CPT) codes, descriptions, and other date are copyright by the American Medical Association. All rights reserved. CPT is a trademark of the American Medical Association.

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SECTION 1
MO HealthNet PROGRAM RESOURCES
Informational Resources available at www.dss.mo.gov/mhd

CONTACTING MO HealthNet

PROVIDER COMMUNICATIONS
The following phone numbers are available for MO HealthNet (formerly Missouri Medicaid) providers to call with inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, and participant eligibility questions and verification.

Provider Communications	(573) 751-2896
Interactive Voice Response (IVR)	(573) 635-8908

A function has been added to the (573) 751-2896 Provider Communications Unit telephone number. When you call the number, you no longer get a busy signal but instead you are automatically transferred to the IVR. Anytime during the IVR options, you may select "0" to speak to the next available specialist. Your call will be put into a queue and will be answered in the order it was received. The Provider Communications Unit also processes written inquires. Written inquiries should be sent to:

Provider Communications Unit
PO Box 5500
Jefferson City, Missouri 65102

The (573) 635-8908 number provides an interactive voice response (IVR) system that can address participant eligibility, last two check amounts and claim status inquiries. It also provides access to a MO HealthNet phone specialist. Providers must use a touchtone phone to access the IVR.

INFOCROSSING HEALTHCARE SERVICES, INC. HELP DESK
(573) 635-3559
Call this number for assistance in establishing the required electronic claims and remittance advice formats, network communication, HIPAA trading partner agreements and assistance with the Infocrossing Internet billing service.

PROVIDER INQUIRIES BY E-MAIL
Providers have the ability to send/receive secure E-mail inquiries to MO HealthNet Provider Communications and Technical Help Desk staff. This application is available through the MO HealthNet Web portal page at www.emomed.com.

Once you have logged in and are on the Home Page, select the 'contact us' option located at the bottom right of the page to be linked to a Provider Inquiry form. Field-by-field instructions for completing the inquiry form can be obtained by clicking on the 'Help' option at the bottom of the page. An asterisk in a field indicates a required field.

Providers are limited to one inquiry per E-mail.

Inquiry Type
The Inquiry Type field on the Provider Inquiry form includes a drop-down box prompting providers to choose the type of inquiry being sent; Claims/Policy or Technical Support. This will determine the routing of the E-mail. This is a required field and the user will be required to select the correct inquiry type.

Select Claims/Policy for inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, benefits and limitations or participant eligibility questions and verification.

Select Technical Support for assistance in establishing the required electronic claims and remittance advice formats, questions regarding user IDs, network communication, HIPAA trading partner agreements, system access problems or any other electronic or technical issue. Refer to MO HealthNet Provider Bulletin, Volume 31 Number 56 Provider E-Mail Inquires dated March 6, 2009.

Confirmation of E-mail
When a user completes and submits the Provider Inquiry form, the user receives an on-screen acknowledgement showing receipt of the inquiry. The acknowledgement immediately displays a summary of the information keyed on the inquiry form and a reference number for the user to reference at a later date. Once submitted, the information keyed on the Provider Inquiry acknowledgment is locked from editing by any user.

MO HealthNet E-mail Response
The user submitting the E-mail inquiry will be notified via E-mail when they have a response available to their inquiry. The E-mail is sent to the E-mail address on the Provider Inquiry form that was originally submitted. The E-mail links the user to www.emomed.com which requires the user to log on and choose the 'View Inquiries by Status" option located at the bottom right of the home page. The provider can then view the response.

Helpful Suggestions
• Remember that you can submit only one inquiry per E-mail.
• Make sure the inquiry includes all specifics. For instance, if you question why claims are not paying or why claims are being denied, please include the participant's DCN, the date of service, billed amount, ICN, billing provider's NPI, etc.
• If asking a general question, such as whether or not a code is covered, please include specifics such as the participant's DCN since certain codes or services may or may not be covered for all eligible participants.
• Make sure the call-back telephone number on the Provider Inquiry form is a valid phone number and if applicable, an extension number. This field is automatically populated with the telephone number on file for the provider. The user has the ability to edit this field.

PROVIDER ENROLLMENT

Providers can contact Provider Enrollment via E-mail as follows for questions regarding enrollment applications: providerenrollment@dss.mo.gov.

Changes regarding address, ownership, tax identification number, name (provider or practice), or National Provider Identifier (NPI) number must be submitted in writing to:

>   Provider Enrollment Unit
>   MO HealthNet Division
>   PO Box 6500
>   Jefferson City, Missouri 65102

THIRD PARTY LIABILITY
(573) 751-2005

Call the Third Party Liability Unit to report injuries sustained by MO HealthNet participants, problems obtaining a response from an insurance carrier, or unusual situations concerning third party insurance coverage for a MO HealthNet participant.

PROVIDER EDUCATION
(573) 751-6683

Provider Education Unit staff are available to educate providers and other groups on proper billing methods and procedures for MO HealthNet claims. Contact the Unit for training information and scheduling.

PARTICIPANT SERVICES
(800) 392-2161 or (573) 751-6527

The Participant Services Unit assists participants regarding access to providers, eligibility, covered and non-covered services and unpaid medical bills.

MO HEALTHNET PHARMACY AND MEDICAL PRE-CERTIFICATION HELP DESK
(800) 392-8030

Providers can call this toll free number to: request a pre-certification for a radiological procedure (CAT scan and MRI); to initiate an emergency request for an essential medical service or an item of equipment that would not normally be covered under the MO HealthNet program; to request information on Medicare Part D; or, to request a drug prior authorization. The MO HealthNet fax line for non-emergency service or equipment exception requests only is (573) 522-3061; the fax line to obtain a drug prior authorization is (573) 636-6470.   Do **not** use either of these numbers for requests for pre-certifications of MRI and CAT scan procedures.

Effective July 17, 2006, MHD implemented pre-certification for certain radiological procedures (CT and MRI). In order for providers to be reimbursed for these services, the participant must meet certain medical criteria and the physician must obtain the pre-certification for the procedure unless performed in an inpatient hospital or emergency room setting. Approved pre-certification requests are given a 14 day approval period.

The list of medical imaging procedures and durable medical equipment and supplies that currently require pre-certification along with the related medical criteria can be referenced at the MO HealthNet Web site
 www.dss.mo.gov/mhd/cs/medprecert/pages/medprecert.htm.

Before initiating a request, providers are encouraged to sign up for the MO HealthNet web tool – CyberAccess – which automates the pre-certification process. To become a CyberAccess user, contact the ACS Heritage help desk at 1-888-581-9797 or 573-632-9797, or send an e-mail to MoHealthNetCyberAccess@heritage-info.com**.** The CyberAccess tool allows each request for pre-certification to automatically reference the individual participant's claim history, including ICD-9 diagnosis codes and CPT procedure codes. Requests for pre-certification will also be taken by the MO HealthNet call center at 800-392-8030 option 2. Requests must meet medical criteria established by MHD in order to be approved.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) INFORMATION

Billing providers who want to exchange electronic information transactions with MO HealthNet can access the *HIPAA-EDI Companion Guide* online by going to the MO HealthNet Division Web page at www.dss.mo.gov/mhd and clicking on the "Providers" link at the top of the page. On the Provider Participation page, click on the HIPAA-EDI Companion Guide link in the column on the left hand side of the page. This will take you directly to the EDI Companion Guide and X12N Version 4010A1 Companion Guide links.

For information on the MO HealthNet Trading Partner Agreement, click on the link to Section 1- Getting Started, then select Trading Partner Registration.

All questions concerning the Trading Partner Agreement or provider testing schedules are to be directed to the Infocrossing Healthcare Services Help Desk, (573) 635-3559.

<u>INTERACTIVE VOICE RESPONSE (IVR)</u>
(573) 635-8908

The Provider Communications Unit Interactive Voice Response (IVR) system, (573) 635-8908, requires a touchtone phone. The ten-digit National Provider Identifier number **must** be entered each time any of the IVR options are accessed. Callers are limited to ten inquiries per call on any of the options except option "0". Providers whose numbers are inactive may utilize the IVR only for dates of service during their active status.

Option 0   <u>Provides access to a MO HealthNet phone specialist.</u>

If all the specialists are busy with other calls, the caller is put into a queue until the next specialist is available. Calls are taken in the order in which they are received. Callers selecting this option are limited to three inquiries per call. Limiting the number of inquiries to three allows communications specialists to respond to more provider calls.

Option 1   Participant Eligibility   Participant eligibility **must** be verified **each** time a participant presents and should be verified **prior** to the service. Eligibility information can be obtained by a participant's MO HealthNet number (DCN), social security number and date of birth, or if a newborn, using the mother's MO HealthNet number and the baby's date of birth. Callers cannot inquire on dates that exceed one year prior to the current date. Callers will be given a confirmation number and this number should be kept as proof of the information received.

Option 2   Last Two Check Amounts
Using this option, the caller will be given the last two Remittance Advice (RA) dates, RA numbers, and check amounts.

Option 3   Claim Status
After entering the participant's MO HealthNet number (DCN) and the date of service, the caller will be provided the status of the most current claim in the system containing the date of service entered. The caller will be told whether the claim is paid, denied, approved to pay or is being processed. In addition, the system will give the amount paid, the RA date and the Internal Control Number (ICN).

INTERNET SERVICES FOR MO HealthNet PROVIDERS

The MO HealthNet Division, in cooperation with Infocrossing Healthcare Services, has an Internet service for MO HealthNet providers. MO HealthNet providers have the ability to:

- Submit claims and receive claim confirmation files;
- Verify participant eligibility;
- Obtain remittance advices (RAs);
- Submit adjustments;
- Submit attachments;
- View claim, attachment and prior authorization (PA) status; and
- View and download public files.

The Web site address for this service is www.emomed.com. Without proper authorization, providers are unable to access the site. Only providers who are approved to be electronic billers can enroll and utilize the Web site services. To participate in the service, the provider must apply online at www.dss.mo.gov/mhd/providers/index.htm.

Each user is required to complete this online application in order to obtain a user ID and password. The application process only takes a few minutes and provides the applicant with a real-time confirmation response, user ID and password. Once the user ID and password have been received, the user can begin using the www.emomed.com Web site. The password can be changed to one of the user's own choice.

Questions regarding the completion of the online Internet application should be directed to the Infocrossing Healthcare Services Help Desk, (573) 635-3559. *An authorization is required for each individual person within a provider's office or a billing service who will be accessing the Internet site.*

This Web site, www.emomed.com, allows for the submission of the following HIPAA compliant transactions:

837 Institutional Claims	Batched or Individual
837 Professional Claims	Batched or Individual
837 Dental Claims	Batched or Individual
270 Eligibility Inquiry	Batched or Individual
276 Claim Status Inquiry	Batched or Individual

The following standard responses are generated:

835 Remittance Advice	Batch or Printable RA
271 Eligibility Response	Batch or Individual
277 Claim Status Response	Batch or Individual

Users also have access to provider check amounts and the Claims Processing Schedule for the current fiscal year.

There is no cost for this service except for the cost of an Internet service provider access to the Internet. Additionally, there are no special software requirements. However, the user (provider) must have the proper Web browser. The provider must have one of the following Web browsers: Internet Explorer 6.0 or higher or Netscape 7.0 or higher. The Internet site is available 24 hours a day, 7 days a week with the exception of being down for scheduled maintenance.

VERIFYING PARTICIPANT ELIGIBILITY THROUGH THE INTERNET
Providers can access MO HealthNet participant eligibility files via the Web site. Functions include eligibility verification by participant ID, casehead ID and child's date of birth, or Social Security number and date of birth. Eligibility verification can be performed on an individual basis or in a batch file. Individual eligibility verification occurs in real-time basis similar to the Interactive Voice Response System, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.

A batch eligibility confirmation file can either be downloaded for viewing purposes or to be printed.

MO HealthNet CLAIMS SUBMISSION THROUGH THE INTERNET

The following claim types, as defined by HIPAA Transaction and Code Set regulations, can be used for Internet claim submissions:

> ➢ 837 - Health Care Claim
> > Professional
> > Dental
> > Institutional (hospital inpatient and outpatient, nursing home, and home health care)
> ➢ Pharmacy (NCPDP)

The field requirements and filing instructions are similar to those for paper claim submissions. For the provider's convenience, some of the claim input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

A batch claim confirmation file can either be downloaded for viewing purposes or to be printed.

Note – Currently, some claims cannot be submitted electronically if an attachment is required unless the attachment is one of the following that can be submitted via the Infocrossing Internet Web service: Sterilization Consent, Second Surgical Opinion, Acknowledgement of Receipt of Hysterectomy Information, the PI-118 Referral (Lock-In) form, Certificate of Medical Necessity or the Invoice of Cost.

OBTAINING A REMITTANCE ADVICE THROUGH THE INTERNET

The MO HealthNet program phased out the mailing of paper Remittance Advices (RAs). Providers no longer receive both paper and electronic RAs. If the provider or the provider's billing service currently receives an electronic RA, (either via the emomed.com Internet Web site or other method), paper copies of the RA were discontinued. All providers and billers must have Internet access to obtain the printable electronic RA via the Infocrossing Internet service, emomed.com.

Receiving the Remittance Advice via the Internet is beneficial to the provider or biller's operation. With the Internet RA, a user can:

- Retrieve the RA the Monday following the weekend claim processing cycle (two weeks earlier than receipt of the paper RA);
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from the desktop; and,
- Download the RA into the provider or biller's operating system for retrieval at a later date.

The Internet RA is viewable and printable in a ready to use format. Just point and click to print the RA or save it to the computer system for printing at the user's convenience.

To sign up for this service, see the instructions at the beginning of this information on Internet services. If a provider does not have access to the Internet, contact the Infocrossing Help Desk, (573) 635-3559, to learn how to obtain a paper remittance.

ADJUSTMENTS THROUGH THE INTERNET
Providers have options on the Internet Medical, Dental, Inpatient, Outpatient and Nursing Home claims for a "Frequency Code" that will allow either a 7 – Replacement (Adjustment) or an 8 – Void (Credit). This will control an individual adjustment or void, but not group adjustments or voids. Claim adjustments and credits can be submitted by utilizing the CLM, field CLMO5-3, segment of the 837 Health Care Claim.

RECEIVE PUBLIC FILES THROUGH THE INTERNET
Several public files are available for viewing or downloading from the Web site including the claims processing schedule for the State fiscal year which begins July 1 and ends June 30. Providers also have access to a listing of the HIPAA related claim codes and other HIPAA related codes.

SUBMIT ATTACHMENTS AND FORMS THROUGH THE INTERNET
Providers can submit required attachments and forms via the Internet as an option to mailing paper versions to MO HealthNet. A paper copy of any attachment or form submitted via the Internet must be kept with the patient's record. The following forms can be submitted through the Infocrossing Internet service.

> Sterilization Consent,
> Second Surgical Opinion,
> PI 118 Referral (administrative lock-in), and,
> Acknowledgment of Receipt of Hysterectomy Information
> Certificate of Medical Necessity
> Invoice of Cost

MO HealthNet PROVIDER MANUALS
AND BULLETINS ONLINE
www.dss.mo.gov/mhd/providers/index.htm

MO HealthNet provider manuals are available online at the MHD Web site, www.dss.mo.gov/mhd/providers/index.htm. Scroll to the bottom of the Provider Participation page and click on the "Provider Manuals" link. The next page displays a State of Missouri MO HealthNet Web portal page with an alphabetical listing of the MO Health Net provider manuals. Click on the appropriate manual link and when it opens, choose the section you want to view. The entire section, portions of a section or the current page displayed can be printed using the print feature on the computer toolbar.

MO HealthNet provider bulletins are also available at the MO HealthNet Web site. The bulletins are published to notify providers of new program and policy changes or to clarify existing policy. To access the bulletins, click on the Provider Bulletin link on the Provider Participation page. The bulletins appear online at this location until the provider manuals are updated with the information contained in the bulletins. Once the manuals are updated, the bulletins are moved to the Archived Bulletin location.

CLAIM PROCESSING SCHEDULE FOR FISCAL YEAR 2013

FINANCIAL CYCLE DATE**		PROVIDER CHECK DATE	
Friday	06/22/2012	Thursday	07/05/2012
Friday	07/06/2012	Friday	07/20/2012
Friday	07/20/2012	Friday	08/03/2012
Friday	08/10/2012	Friday	08/17/2012
Friday	08/24/2012	Wednesday	09/05/2012
Friday	09/07/2012	Friday	09/21/2012
Friday	09/21/2012	Friday	10/05/2012
Friday	10/12/2012	Friday	10/19/2012
Friday	10/26/2012	Monday	11/05/2012
Friday	11/09/2012	Tuesday	11/20/2012
Friday	11/23/2012	Wednesday	12/05/2012
Friday	12/14/2012	Friday	12/21/2012
Friday	12/28/2012	Monday	01/07/2013
Friday	01/11/2013	Tuesday	01/22/2013
Friday	01/25/2013	Tuesday	02/05/2013
Friday	02/08/2013	Wednesday	02/20/2013
Friday	02/22/2013	Tuesday	03/05/2013
Friday	03/08/2013	Wednesday	03/20/2013
Friday	03/22/2013	Friday	04/05/2013
Friday	04/05/2013	Friday	04/19/2013
Friday	04/19/2013	Friday	05/03/2013
Friday	05/10/2013	Friday	05/17/2013
Friday	05/24/2013	Wednesday	06/05/2013
Friday	06/07/2013	Thursday	06/20/2013

***Closeout is 5:00 p.m. on the date shown

State Holidays

July 4, 2012 Independence Day	January 1, 2013 New Year's Day
September 3, 2012 Labor Day	January 21, 2013 Martin Luther King's Birthday
October 8, 2012 Columbus Day	February 12, 2013 Lincoln's Birthday
November 12, 2012 Veteran's Day	February 18, 2013 Washington's Birthday
November 22, 2012 Thanksgiving Day	May 8, 2013 Truman's Birthday
December 25, 2012 Christmas Day	May 27, 2013 Memorial Day

SECTION 2
CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. MO HealthNet (formerly known as Missouri Medicaid) paper claims should be mailed to:

> Infocrossing Healthcare Services, Inc.
> P.O. Box 5600
> Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3 of the MO HealthNet *Providers Manual* available at www.dss.mo.gov/mhd/providers/index.htm**.**

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

Field number and name	**Instructions for completion**
1. Type of Health Insurance Coverage	Show the type of health insurance coverage applicable to this claim by checking the appropriate box.
1a.* Insured's I.D.	Enter the patient's eight-digit MO HealthNet ID number (DCN) as shown on the patient's ID card.
2.* Patient's Name	Enter last name, first name, middle initial *in this order* as it appears on the patient's ID card.
3. Patient's Birth Date Sex	Enter month, day, and year of birth. Mark appropriate box.
4.** Insured's Name	If there is individual or group insurance besides MO HealthNet, enter the name of the primary policyholder. If this field is completed, also complete fields 6, 7, 11, and 13. If no private insurance is involved, leave blank.
5. Patient's Address	Enter address and telephone number if available.

Field number and name   **Instructions for completion**

6.**   Patient Relationship   Mark appropriate box if there is other
            to Insured   insurance. If no private insurance is involved,
                                          leave blank.

7.**   Insured's Address   Enter the primary policyholder's address; enter
                                          policy-holder's telephone number, if available.
                                          If no private insurance is involved, leave blank.

8.   Patient Status   Not required.

9.**   Other Insured's Name   If there is other insurance coverage in
                                          addition to the primary policy, enter the
                                          secondary policyholder's name. If no private
                                          insurance is involved, leave blank. [See Note
                                          (1)]

9a.**   Other Insured's Policy or   Enter the secondary policyholder's insurance
            Group Number   policy number or group number, if the
                                          insurance is through a group such as an
                                          employer, union, etc. If no private insurance is
                                          involved, leave blank. [See Note (1)]

9b.**   Other Insured's Date of Birth Enter the secondary policyholder's date of birth
                                          and mark the appropriate box for the sex of the
                                          secondary policyholder. If no private insurance
                                          is involved, leave blank. [See Note (1)]

9c.**   Employer's Name   Enter the secondary policyholder's
                                          employer's name. If no private insurance is
                                          involved, leave blank. [See Note (1)]

9d.**   Insurance Plan Name   Enter the secondary policyholder's insurance
            or Program Name.   plan or program name. If no private insurance
                                          is involved, leave blank.

                                          If the insurance plan denied payment for the
                                          service provided, attach a valid denial from the
                                          insurance plan. [See Note (1)]

10a.-10c.** Is Patient's Condition   If services on the claim are related to patient's
            Related to: employment, an auto accident or other
                                          accident, mark the appropriate box. **If the**
                                          services are not related to an accident,
                                          leave blank. [See Note (1)]

Field number and name   **Instructions for completion**

10d.   Reserved for Local Use   May be used for comments/descriptions.

11.**   Insured's Policy or   Enter the primary policyholder's insurance
        FECA Number   policy number or group number, if the
                                            insurance is through a group, such as an
                                            employer, union, etc. If no private insurance is
                                            involved, leave blank. [See Note (1)]

11a.** Insured's Date of Birth   Enter primary policyholder's date of birth and
                                            mark the appropriate box for the sex of the
                                            primary policyholder. If no private insurance is
                                            involved, leave blank. [See Note (1)]

11b.** Employer's Name   Enter the primary policyholder's employer
                                            name. If no private insurance is involved,
                                            leave blank. [See Note (1)]

11c.** Insurance Plan Name   Enter the primary policyholder's insurance plan
        or Program Name   name.

                                            *If the insurance plan denied payment for the
                                            service provided, attach a valid denial from the
                                            insurance plan.* [See Note (1)]

11d.** Other Health Plan   Indicate whether the patient has a secondary
                                            health insurance plan. If so, complete
                                            fields 9-9d with the secondary insurance
                                            information. If no private insurance is involved,
                                            leave blank. [See Note (1)]

12.   Patient's Signature   Leave blank.

13.   Insured's Signature   This field should be completed only when the
                                            patient has another health insurance policy.
                                            Obtain the policyholder's or authorized
                                            person's signature for assignment of benefits.
                                            The signature is necessary to ensure the
                                            insurance plan pays any benefits directly to the
                                            provider of MO HealthNet. Payment may
                                            otherwise be issued to the policyholder
                                            requiring the provider to collect insurance
                                            benefits from the policyholder.

Field number and name　　　　　　　　　**Instructions for completion**

14.**　Date of Current Illness, Injury　　*This field is required when billing global*
　　　　or Pregnancy　　　　　　　　　*prenatal and delivery services.* The date
　　　　　　　　　　　　　　　　　　　should reflect the last menstrual period (LMP).

15.　　Date Same/Similar Illness　　　Leave blank.

16.　　Dates Patient Unable to Work　Leave blank.

17.**　Name of Referring Provider　　Enter the name of the referring provider or
　　　　or Other Source　　　　　　　other source. If multiple providers are
　　　　　　　　　　　　　　　　　　　involved, enter one provider using the following
　　　　　　　　　　　　　　　　　　　priority order: 1) referring provider; 2) ordering
　　　　　　　　　　　　　　　　　　　provider; or, 3) supervising provider.

　　　　　　　　　　　　　　　　　　　If the physician is nonparticipating in the MO
　　　　　　　　　　　　　　　　　　　HealthNet program, enter "nonparticipating."

　　　　　　　　　　　　　　　　　　　This field is required for independent
　　　　　　　　　　　　　　　　　　　laboratories and independent radiology groups
　　　　　　　　　　　　　　　　　　　and providers with a specialty of "30"
　　　　　　　　　　　　　　　　　　　(radiology/radiation therapy).

17a.**　Other ID　　　　　　　　　　Enter the Provider Taxonomy qualifier ZZ in
　　　　　　　　　　　　　　　　　　　the first shaded area if the provider reported in
　　　　　　　　　　　　　　　　　　　17b is required to report a Provider Taxonomy
　　　　　　　　　　　　　　　　　　　Code to MO HealthNet. Enter the
　　　　　　　　　　　　　　　　　　　corresponding 10-digit Provider Taxonomy
　　　　　　　　　　　　　　　　　　　Code in the second shaded area for the
　　　　　　　　　　　　　　　　　　　provider reported in 17b.

　　　　　　　　　　　　　　　　　　　This field is required for independent
　　　　　　　　　　　　　　　　　　　laboratories and independent radiology groups
　　　　　　　　　　　　　　　　　　　and providers with a specialty of "30"
　　　　　　　　　　　　　　　　　　　(radiology/radiation therapy).

17b.**NPI　　　　　　　　　　　　　Enter the NPI number of the referring, ordering
　　　　　　　　　　　　　　　　　　　or supervising provider

　　　　　　　　　　　　　　　　　　　This field is required for independent
　　　　　　　　　　　　　　　　　　　laboratories and independent radiology groups
　　　　　　　　　　　　　　　　　　　and providers with a specialty of "30"
　　　　　　　　　　　　　　　　　　　(radiology/radiation therapy).

Field number and name   **Instructions for completion**

18.**   Hospitalization Dates   If the services on the claim were provided in an inpatient hospital setting, enter the admit date.

                                            This field is required if services were provided in an inpatient hospital setting.

19. Reserved for Local Use   Providers may use this field for additional remarks/descriptions.

20.**   Lab Work Performed   If billing for laboratory charges, mark the
            Outside Office   appropriate box. The referring physician may **not** bill for lab work that was referred out.

21.*   Diagnosis   Enter the complete ICD-9-CM diagnosis code(s). Enter the primary diagnosis as No. 1, the secondary diagnosis as No. 2, etc.

22.**   MO HealthNet Resubmission   For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.

23.   Prior Authorization Number   Leave blank**.**

24a.*   Date of Service   Enter the date of service under "from" in the month/day/year format using the six digit format in the unshaded area of the field. All line items must have a from date. A "to" date of service is required when billing on a single line for subsequent physician hospital visits on consecutive days.

                                            The six service lines have been divided to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top area of the service lines is shaded and is the location for reporting supplemental information. It is **not** intended to allow the billing of 12 lines of service.

Field number and name	**Instructions for completion**

24b.* Place of Service

Enter the appropriate place of service code in the unshaded area of the field. See Section 15.8 of the MO HealthNet *Physician's Provider Manual* for the list of appropriate place of service codes.

24c.   EMG-Emergency

Enter a Y in the unshaded area of the field. If this is not an emergency, leave this field blank.

24d.* Procedure Code

Enter the appropriate CPT or HCPCS code and applicable modifier(s), if any, corresponding to the service rendered. (Field 19 may be used for remarks or descriptions.)

24e.* Diagnosis Pointer

Enter 1, 2, 3, 4 or the actual diagnosis code(s) from field 21 in the unshaded area of the field.

24f.* Charges

Enter the provider's usual and customary charge for each line item in the unshaded area of the field. This should be the total charge if multiple days or units are shown.

24g.* Days or Units

Enter the number of days or units of service provided for each detail line in the unshaded area of this field. The system automatically plugs a "1" if the field is left blank.

Anesthesia—Enter the total number of minutes of anesthesia.

Consecutive visits—Subsequent hospital visits may be billed on one line if they occur on consecutive days. The days/units must reflect the total number of days shown in field 24a.

24h.** EPSDT/Family Planning

If the service is an EPSDT/HCY screening service or referral, enter "E." If the service is family planning related, enter "F." If the service is both an EPSDT/HCY and Family Planning service enter "B."

24i.   ID Qualifier

Enter the Provider Taxonomy qualifier ZZ in the shaded area if the rendering/performing provider is required to report a Provider Taxonomy Code to MO HealthNet.

Field number and name   **Instructions for completion**

24j.**   Rendering Provider ID   If the Provider Taxonomy qualifier was
                                        reported in 24i, enter the 10-digit Provider
                                        Taxonomy Code in the shaded area. Enter the
                                        10-digit NPI number of the individual
                                        rendering/performing the service in the
                                        unshaded area.

                                        Required for a clinic, FQHC, radiology group,
                                        teaching institution or a group practice only.

25.   SS#/Fed. Tax ID   Leave blank.

26.   Patient Account Number   For the provider's own information, a maximum
                                        of 12 alpha and/or numeric characters may be
                                        entered here.

27.   Assignment   Not required on MO HealthNet claims.

28.*   Total Charge   Enter the sum of the line item charges.

29.**   Amount Paid   Enter the total amount received by all other
                                        insurance resources. **Previous MO HealthNet
                                        payments, Medicare payments, cost
                                        sharing and co-pay amounts are not to be
                                        entered in this field.**

30.   Balance Due   Enter the difference between the total charge
                                        (field 28) and any insurance amount paid (field
                                        29).

31.   Provider Signature   Leave blank.

32.**   Name and Address of Facility   If the services were rendered in a facility other
                                        than the home or office, enter the name and
                                        location of the facility.

                                        This field is required when the place of service
                                        is other than home or office.

32a.** NPI Number   Enter the 10 digit NPI number of the service
                                        facility location reported in field 32.

32b ** Other ID Number   Enter the Provider Taxonomy qualifier ZZ and
                                        the 10-digit Provider Taxonomy Code for the
                                        NPI number reported in 32a if the provider is

Field number and name   **Instructions for completion**

                                                   is required to report a Provider Taxonomy
                                                   Code to MO HealthNet. Do not enter a space,
                                                   hyphen or other separator between the
                                                   qualifier and the Taxonomy Code.

33.*   Provider Name/ Number   Affix the provider label or write or type the
        /Address   information **exactly** as it appears on the label.

33a. * NPI Number   Enter the NPI number of the billing provider
                                                   listed in field 33.

33b. * Other ID Number   Enter the Provider Taxonomy qualifier ZZ and
                                                   the 10-digit Provider Taxonomy Code for the
                                                   NPI number reported in 33a if the provider is
                                                   required to report a Provider Taxonomy Code
                                                   to MO HealthNet. Do not enter a space,
                                                   hyphen or other separator between the
                                                   qualifier and theTaxonomy Code.

*   These fields are mandatory on all CMS-1500 claim forms.

**   These fields are mandatory only in specific situations as described.

(1)   NOTE: This field is for private insurance information only. If no private insurance
        is involved, **leave blank**. If Medicare, MO HealthNet, employers name or other
        information appears in this field, the claim will deny. See Section 5 of the MO
        HealthNet *Provider's Manual* for further TPL (Third Party Liability) information.

SECTION 3
THE REMITTANCE ADVICE

MO HealthNet (formerly known as Missouri Medicaid) has discontinued printing and mailing paper Remittance Advices (RAs) to most providers. The remittance advices are available via the Internet through emomed.com. There are three versions available, the 837 format, a proprietary version and the Printable RA.

Using emomed.com, providers can:

- Retrieve a remittance advice the Monday following the weekend Financial Cycle run (two weeks sooner than the paper version);
- View and print the RA from your desktop; and
- Download the RA into your computer system for future reference.

More information on accessing and using the printable RA is found later in this section.

When a claim is adjudicated, it is included as a line item on the next RA. Along with listing the claim, the RA lists an "Adjustment Reason Code" to explain a payment, denial or other action. The Adjustment Reason Code is from a national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's reimbursement for it. The RA may also list a "Remittance Remark Code" which is from the same national administrative code set that indicates either a claim-level or service-level message that cannot be expressed with a claim Adjustment Reason Code. The Adjustment Reason Codes and Remittance Remark Codes may be found on the MO HealthNet Division Web site, www.dss.mo.gov//mhd/providers/index.htm, and clicking on the link "HIPAA related code lists".

The date on the RA is the date the final processing cycle runs. Reimbursement will be made through a mailed check or a direct bank deposit approximately two weeks after the cycle run date. (See the Claims Processing Schedule at the end of Section 1.)

The RA is grouped first by paid claims and then by denied claims. Claims in each category are listed alphabetically by the patient's last name. If the patient's name and/or Departmental Client Number (DCN) are **not** on file, only the first two letters of the last name and first letter of the first name appear.

Each claim entered into the claims processing system is assigned a 13-digit Internal Control Number (ICN) assigned for identification purposes. The first two digits of an ICN indicate the type of claim.

15 – CMS 1500 paper claim
49 – Internet claim
70 – Individual Credit to an Adjustment

      50 – Individual Adjustment Request
      75 – Credit Mass Adjustment
      55 – Mass Adjustment

The third and fourth digits indicate the year the claim was received. The fifth, sixth, and seventh digits indicate the Julian date the claim was entered into the system. In the Julian system, the days are numbered consecutively from "001" (January 01) to "365" or "366" in a leap year (December 31). The last digits of an ICN are for internal processing.

The ICN 1508059731500 is read as a CMS 1500 paper medical claim entered in the processing system on February 28, 2008.

If a claim is denied, a new or corrected claim form **must** be submitted as corrections **cannot** be made by submitting changes on the printed RA pages.

When a claim denies for other insurance, the commercial carrier information is shown. Up to two policies can be shown.

PRINTABLE REMITTANCE ADVICE

The Printable Internet Remittance Advice is accessed at www.emomed.com. A provider must be enrolled with emomed.com in order to access the Web site and the printable RA. To sign-up for emomed.com and the on-line Remittance Advice option, visit the MO HealthNet Web site, www.dss.mo.gov/mhd/providers/index.htm, and select the "Internet access" link.

On the Printable Remittance Advice page, click on the RA date you wish to view, print or save and follow your Internet browser's instructions. The RA is in the PDF file format. Your browser will open the file directly if you have Adobe Acrobat Reader installed on your computer. If you do not have this program, go to http://www.adobe.com/products/acrobat/readstep2.htm to download it to your computer.

RAs are available automatically following each financial cycle. Each RA remains available for a total of 62 days. The oldest RA drops off as the newest becomes available. Therefore, providers are encouraged to save each RA to their computer system for future reference and use.

Note: When printing an RA, it is set to page break after 70 lines per page.

If a provider did not save an RA to his/her computer and wants access to an RA that is no longer available, the provider can request the RA through the "Aged RA Request" link on the emomed.com home page.

In general, the Printable Remittance Advice is displayed as follows.

FIELD	DESCRIPTION
PARTICIPANT'S NAME	The participant's last name and first name. NOTE: If the participant's name and identification number are not on file, only the first two letters of the last name and first letter of the first name appear.
MO HEALTHNET ID	The participant's 8-digit MO HealthNet identification number.
ICN	The 13-digit number assigned to the claim for identification purposes.
SERVICE DATES FROM	The initial date of service in MMDDYY format for the claim.
SERVICE DATES TO	The final date of service in MMDDYY format for the claim
PAT ACCT	The provider's own patient account name or number.
CLAIM ST	This field reflects the status of the claim. Values are: 1 = Processed as Primary, 3 = Processed as Tertiary, 4 = Denied, 22 = Reversal of Previous Payment
TOT BILLED	The total claim amount submitted.
TOT PAID	The total amount MO HealthNet paid on the claim.
TOT OTHER	The combined totals for patient liability (surplus), recipient co-pay, and spenddown total withheld.
LN	The line number of the billed service.
SERVICE DATES	The date of service(s) for the specific detail line.
REV/PROC/NDC	The submitted procedure code, NDC, or revenue code for the specific detail line. Note: The revenue code will only appear in this field if a procedure code is not present.
MOD	The submitted modifier(s) for the specific detail line.
REV CODE	The submitted revenue code for the specific detail line. Note: The revenue code only appears in this field if a procedure code has also been submitted.

FIELD	**DESCRIPTION**
QTY	The units of service submitted
BILLED AMOUNT	The submitted billed amount for the specific detail line
ALLOWED AMOUNT	The MO HealthNet maximum allowed amount for the procedure.
PAID AMOUNT	The amount MO HealthNet paid on the claim.
PER PROV	The National Provider Identifier (NPI) for the performing provider submitted at the detail.
SUBMITTER LN ITM CNTL	The submitted line item control number.
GROUP CODE	The Claim Adjustment Group Code is a code identifying the general category of payment adjustment. Values are: CO = Contractual Obligation CR = Correction and Reversals OA = Other Adjustment PI = Payer Initiated Reductions PR = Patient Responsibility
RSN	The Claim Adjustment Reason Code is the code identifying the detailed reason the adjustment was made.
AMT	The dollar amount adjusted for the corresponding reason code.
QTY	The adjustment to the submitted units of service. This field will not be printed if the value is zero.
REMARK CODES	The Code List Qualifier Code and the Health Care Remark Code (Remittance Advice Remark Codes). The Code List Qualifier Code is a code identifying a specific industry code list. Values are: HE = Claim Payment Remark Code RX = National Council for Prescription Drug Programs Reject/Payment Codes. The Health Care Remark Codes (Remittance Advice Remark Codes) are codes used to convey information about remittance processing or to provide a

FIELD   **DESCRIPTION**

supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.

CATEGORY TOTALS   Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount, allowed amount, and paid amount.

HCY SCREENINGS

Developmental/Mental Health Partial Screens are billable by a provisionally licensed psychologist, psychologist, psychiatrist, psychiatric mental health practitioner (PMHNP), psychiatric clinical nurse specialist (PCNS), LCSW, LMSW, LPC, or PLPC. These screening codes do not use the AH, AJ, UD, or U8 modifiers. Instead the codes must have a 59 modifier and if the child is referred on for further care a UC modifier. The diagnosis code V202 is the only valid diagnosis code for a partial HCY screening.

99429 59 / $15.00   99429 59 UC / $15.00

*Modifier "UC" must be used if child was referred for further care as a result of the screening. Modifier "UC" must always appear as the last modifier.

MODIFIERS

Claims must be submitted using the appropriate modifier(s). The specialty modifier is always required.

AH – Psychologist / Provisionally Licensed Psychologist
AJ – Licensed Clinical Social Worker / Licensed Master Social Worker
UD – Licensed Professional Counselor / Provisionally Licensed Professional
       Counselor
U8 – in home (12) or private school (99)
(The U8 modifier is not appropriate when billing 90853 regardless of POS)

A modifier may be required to track services provided to patients identified as catastrophe/disaster victims in any part of the country. This modifier is used in addition to any other required modifiers. There is no additional reimbursement associated with use of this modifier.

CR – Catastrophe/Disaster Related

With the implementation of National Correct Coding Initiative (NCCI), multiple services rendered on the same date by the same performing provider require an additional modifier. A list of modifiers may be found at the fee schedule link on the MHD Web site.

FREQUENTLY USED PLACE OF SERVICE CODES (POS)

04 – Homeless Shelter   11 – Office   12 – Participant Home   14- Group Home
21 – Inpatient Hospital   22 – Outpatient Hospital   33 – Custodial Care Facility
50 – FQHC   51 – Inpatient Psychiatric Facility
56 – Psych Residential Treatment   61 – Comprehensive Inpatient Rehab Facility
72 – Rural Health Clinic   03 – Public School   99 – Private School

Refer to the Behavioral Health Services manual, Section 15, for complete list of POS codes and additional description information, http://manuals.momed.com/manuals.

TIME-BASED SERVICE LIMITATIONS

A therapy procedure code representing a measure of time as defined in the CPT is covered for one (1) unit per day. Behavioral Health Services are for face-to-face services with the participant and/or family member. The participant must be present for all or some of the time. (In reporting, choose the code closest to the actual time (ie, 16-37 minutes for 90832 and 38-52 minutes for 90834. Do not report psychotherapy of less than 16 minutes duration.) MO HealthNet policy has been the participant must be present at least 75% of the time being billed.

Providers may not bill a combination of any psychotherapy codes that have the same description, except for time, on the same date of service. For example a half hour (90832) and 45 minutes (90834) is not covered on the same date of service. MHD does not reimburse for the 60 minute (90837 and 90838) psychotherapy codes.

A psychiatrist, PCNS, or a PMHNP must determine whether the visit is an evaluation and management (E&M) service or a psychotherapy service based on the medical and psychotherapeutic components of the service. MHD does not recognize any add-on codes. Billing of a combination of Psychotherapy and E&M will not be allowed. The E&M codes are not billable by a psychologist, provisional licensed psychologist, LCSW, LMSW, LPC or PLPC.

MHD allows the utilization of the appropriate E&M code when pharmacologic management is provided. Providers will have to include all components associated with the appropriate E&M code including documentation that support the service.

MHD has eliminated any codes labeled interactive. This will not limit the provider's ability to perform interactive services as deemed necessary. The patient's file must document the interactive service was appropriate and the techniques utilized in the session.

Prior to 2013, only Individual Interactive Therapy was approved for most children under the age of 3. Individual Therapy may now be authorized but only with the appropriate documentation to support *utilization* of interactive services. This does not include play therapy.

MHD recognizes two (2) codes for Diagnostic Assessment, Diagnostic Evaluation – 90791 (no medical) and Diagnostic Evaluation – 90792 (with medical). MHD does not recognize the interactive complexity add-on code.

MHD utilizes the Psychotherapy for Crisis code (90839); however, add-on codes will not be recognized. MHD will use the 90839 code for units of services, even those that go beyond the first 60 minutes. Crisis Intervention is limited to 6, 60-minute units per participant, per provider, per calendar year. In order to be reimbursed by MHD, the services must be provided in full 60-minute units.

Currently, the CPT definition for Assessment, Family Therapy with or without the patient present, and Group Therapy is not time limited; and MHD defines a unit of service as a half hour. (These therapies must be provided in full 30-minute units.)

Testing and Psychotherapy for Crisis are defined in the CPT as hour services and a full 60 minutes of services must be provided. MHD does not recognize the 30 minute add-on codes for Psychotherapy for Crisis.

Certain services are not covered when provided by an LCSW, LMSW, PLPC or LPC and may not be billed for an adult or child in any setting. These codes are 96101, 96103, 96105, 96111, and 96116.

Travel time is not reimbursable and must not be included as part of the scheduled appointment time.

FAMILY THERAPY

Family therapy is defined as the treatment of family members as a family unit, rather than an individual patient. When Family Therapy without the Patient Present (90846) or Family Therapy with the Patient Present (90847) is provided, the session is billed as one service (one family unit), regardless of the number of individuals present at the session. Providers may not bill for Family Therapy for each family member. This will be monitored by the Missouri Medicaid Audit and Compliance (MMAC) unit. Treatment of family members (adults) is not covered when provided by an LCSW, LMSW, PLPC, or LPC. Family Therapy furnished by an LCSW, LMSW, PLPC, or LPC must be directed exclusively to the treatment of the child. **Parental issues may not be billed and Family Therapy is only billable when defined in the Treatment Plan as necessary on behalf of the identified patient.**

A psychiatrist, PCNS, PMHNP and provisional licensed psychologist or psychologist may bill for services provided to an adult. When a family consists of a MO HealthNet eligible adult and child(ren) and the therapy is not directed at one specific child, services may be directed to the adult for effective treatment of the family unit to address the adult's issues and impact on the family. If the adult is not eligible and the family therapy is directed to the adult and not the child, the service may not be billed using the child's DCN.

Only one (1) Prior Authorization will be approved and open at a time for Family Therapy. If there is more than one eligible child and no child is exclusively identified as the primary participant of treatment, then the oldest child's DCN must be used for Prior Authorization and billing purposes. When a specific child is identified as the primary participant of treatment, that child's DCN must be used for Prior Authorization and billing purposes. Providers must not request more than one (1) Family Therapy Prior Authorization per family.

A family may be biological, foster, adoptive or other family unit. A family is not a group and **providers may not submit a claim for each eligible person attending the same family therapy session. At least 75% of the session must have both child/children and parent(s) present.**

GROUP THERAPY

Group Therapy must consist of 3 but no more than 10 individuals who are not members of the same family. This applies to inpatient Group Therapy sessions also.

Group Therapy may not be billed on the same date of service as Family Therapy (90846 or 90847) unless the client is inpatient, in a residential treatment facility, or custodial care facility. *Services must be provided at the facility location.* Group Therapy in a group home is billed with POS 14. Group Therapy in a residential/custodial facility is billed with POS 33. Group Therapy in a shelter type setting is billed with POS 04.

PLACE OF SERVICE CODE

The only valid setting for using place of service code 99 is a private school. Place of service 99 cannot be used for therapy provided in a public setting. A public setting includes but is not limited to: a parked or moving vehicle, library, park, shopping center, restaurants, etc. Providers must use the appropriate place of service code for the setting in which services are rendered. If there is no place of service code that matches the setting, services may not be billed to MO HealthNet. Although there is a place of service 15 for mobile unit, MO HealthNet does not cover services provided in this setting.

Place of service 11 (office) is to be used for settings such as a Head Start. Centers for Medicare and Medicaid Services (CMS) has defined an office as a location where the health professional routinely provides services.

Place of service 04 (homeless shelter) should be used when services are provided in a setting such as a crisis center or Salvation Army housing. The CMS definition of a homeless shelter is a facility or location that provides temporary housing.

NURSING HOME

MO HealthNet covers Psychiatric Diagnostic Evaluation, 90791 or 90792, for participants in a nursing home. The Psychiatric Diagnostic Evaluation includes a history, mental status, and a disposition. It may include communication with family or other sources and also the ordering and medical interpretation of laboratory or other medical diagnostic studies. The Psychiatric Diagnostic Evaluation may be done by a psychiatrist, PMHNP, or PCNS.

There are no changes to the established billing guidelines and documentation requirements when a Psychiatric Diagnostic Evaluation is performed in a nursing home setting.

A psychiatrist, PMHNP, or PCNS may also provide pharmacologic management in a nursing home setting using the appropriate Evaluation and Management (E & M) code for the level of care provided.

All other Behavioral Health services are not billable by a psychiatrist, PMHNP, PCNS, provisional licensed psychologist, psychologist, LCSW, LMSW, PLPC, or LPC in the nursing home setting.

SCHOOL BASED SERVICES

Services provided on public school grounds or provided due to an Individualized Education Plan (IEP) are billed by the school district using their National Provider Identifier number (NPI) and the individual's NPI as the performing provider. Reimbursement is made back to the school district. IEP services are exempt from Managed Care but must be prior authorized by MHD based on the ME code. The only appropriate place of service for a public school setting is 03 and must be used.

DIAGNOSIS CODES

The diagnosis code on the claim must be a valid diagnosis code in the current edition of the International Classification of Diseases (ICD-9) code book and must be behavioral health related. **This does not include developmental disabilities**. Currently, the only valid code ranges for the Behavioral Health Services program are 295-316, V11-V118, V154-V1542, V17-V170, V40-V401, V61-V619, V624, V628-V6289, V673, V710-V7102, and V79-V791. An appropriate 4th or 5th digit may be required for the diagnosis code to be valid.

(Psychological services will be covered if they are determined medically necessary when using the diagnostic criteria set forth in the current edition of the DSM. PA approval is based on the current edition of the DSM diagnosis code. However, the diagnosis code on a submitted claim must be an appropriate code in the current edition of the ICD diagnosis code book.)

DOCUMENTATION REQUIREMENTS

DIAGNOSTIC ASSESSMENT

A current Diagnostic Assessment as defined in CSR 70-98.015 from a MO HealthNet enrolled provider must be documented in the client's medical record. This assessment will assist in ensuring an appropriate level of care, identifying necessary services, developing a treatment plan and documenting the following:

- Statement of needs, goals, and treatment expectations from the individual requesting services; the family's perceptions when appropriate and available
- Presenting problem and referral source

- History of previous psychiatric and/or substance abuse treatment including number and type of admissions
- Current medications; medication allergies/adverse reactions
- Recent alcohol/drug use for at least the past 30 days; a substance abuse history including duration, patterns, and consequence of use
- Current psychiatric symptoms
- Family, social, legal, and vocational/educational status and functioning. Historical data is also required unless short-term crisis intervention or detoxification are the only services being provided
- Current use of resources and services from other agencies
- Personal and social resources and strengths, including availability of family, peer, and other natural supports
- Multi-axis diagnosis or diagnostic impression according to the current edition of the DSM or ICD code book. The ICD diagnosis code is required on the treatment plan for billing purposes.

PLAN OF TREATMENT

A current Plan of Treatment as defined in CSR 70-98.015 is required documentation as part of the client's medical record. A treatment plan must be developed based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the client's situation and reflects the need for behavioral health services. The Treatment Plan must be individualized to reflect the unique needs and goals of the client. The Treatment Plan must include but is not limited to the following:

- Measurable goals and outcomes
- How each goal/outcome will be accomplished
    - Services, supports, staff member responsible,
    - Actions required of the participant, family, peers, etc.
- Involvement of family, when indicated
- Identification of and plan for coordinating with other agencies
- Referrals to other organizations for other needed services
- Identification of medications
- Projected time frame for completion of each goal/outcome
- Estimated completion/discharge date

TREATMENT UPDATE:

The Treatment Plan must be reviewed on a periodic basis to evaluate progress towards goals/outcomes and to update the plan. Each client will participate in the review of his/her treatment plan. The frequency of plan reviews is based on the level of care or other program rules. Children under the age of 13 should have their treatment plans

updated at least every 6 months. Children 13 and older and adults should be done at least every year. A crisis or significant event may require additional review and the treatment plan must be updated and changed as indicated. Each update must include the therapist's assessment of current symptoms and behaviors related to diagnosis, progress towards goals, justification of changed or new diagnosis, and response to other concurrent treatments such as family or group therapy and medications. Plans for continuing treatment and/or termination from therapy and aftercare must be expressed in each Treatment Plan update.

PROGRESS NOTES

Progress Notes as defined in CSR 70-98.015 must be written in narrative form, fully describe each session, and be kept in the patient's medical record for each date of service for which a claim is filed. A check-off list or pre-established form is not acceptable as sole documentation. Progress notes for Behavioral Health services must specify:

- First and last name of client
- Specific service rendered
- Date (month/day/year)
- Actual clock begin and end times (1:00 p.m. to 2:00 p.m.)
- Name of person who provided the service
- Setting
- Patient's report of recent symptoms and behaviors related to diagnosis and treatment plan goals
- Therapist's intervention for the visit and participant's response
- The pertinence of the service to the treatment plan
- Patient's progress towards goals in treatment plan
- FamilyTherapy - must identify each member of the family, first and last name, included in the session and
    - Description of immediate issue addressed
    - Identification of underlying roles, conflicts or patterns
    - Description of therapist intervention, patient response, and progress toward specific goal
- Group Therapy - must identify the number of group members present and
    - Description of immediate issue addressed
    - Identification of underlying roles, conflicts or patterns
    - Description of therapist intervention, patient's response, and progress towards goals

(FYI – These are generalized points of CSR 70-98.015. Providers should refer to this rule for a complete description of the documentation requirements.

Note: If interactive therapy is provided, the documentation must include the need for this service and the type of equipment, devices, or other mechanism of equipment used. (This is specifically required per CSR 70-98.015).

If the service is for a child in the legal custody of the Children's Division (CD), a copy of the Treatment Plan must be provided to the CD.

These documentation requirements do not replace or negate documentation/reports required by CD for individuals in their care and custody. Providers are expected to comply with policies and procedures established by CD.

AFTERCARE PLAN

When care is completed, the aftercare plan must include, but is not limited to, the following:

- Dates (care) begin and end
- Frequency and duration of visits
- Target symptoms/behaviors addressed
- Interventions
- Progress achieved towards goals
- Final diagnosis
- Final recommendations including further services, providers, and activities to promote further recovery

For all medically necessary covered services, the stipulated documentation is an essential and integral part of the service. No service will be considered performed if documentation requirements are not met, and no reimbursement will be made.

Only the enrolled MO HealthNet provider can provide Behavioral Health services and be reimbursed. MO HealthNet does not cover services provided by someone other than the enrolled provider.

Services provided by an individual under the direction or supervision of the enrolled provider are not covered.

MO HealthNet providers must retain for six (6) years from the date of service, fiscal and medical records that coincide with and fully document services billed to MO HealthNet and must furnish or make records available for inspection or audit by the Department of Social Services or its representative upon request.

PROCEDURE CODES FOR LCSW AND LPC

The procedure codes listed below are the only behavioral health codes billable by an LCSW, LMSW, LPC, or PLPC. The appropriate AJ or UD must be used for **all** codes.

Procedure Code	Modifier	Maximum Allowed	Maximum Quantity	Description
90791		$24.00	6	Psychiatric diagnostic eval
90791	U8	$29.00	6	Psychiatric diagnostic eval - home
90832		$24.00	1	Individual therapy – 30 mins.
90832	U8	$29.00	1	Individual therapy – home – 30 mins.
90834		$48.00	1	Individual therapy – 45 mins.
90834	U8	$58.00	1	Individual therapy – home – 45 mins..
90846		$24.00	2	Family therapy without patient present
90846	U8	$29.00	2	Family therapy without patient present - home
90847		$24.00	2	Family therapy with patient present
90847	U8	$29.00	2	Family therapy with patient present - home
90853		$10.00	3	Group therapy (other than multi-family)
90839		$48.00	6	Psychotherapy for Crisis – 60 mins.
90839	U8	$53.00	6	Psychotherapy for Crisis – home – 60 mins.
99406**		$6.00	1	Smoking behavior change 3-10 mins.
99407**		$9.00	1	Smoking behavior change over 10 mins.

PROCEDURE CODES FOR PSYCHOLOGISTS

The procedure codes listed below are the only behavioral health codes billable by a *provisional licensed psychologist, or psychologist. The AH modifier must be used on **all** codes.*

Procedure Code	Modifier	Maximum Allowed	Maximum Quantity	Description
90791		$30.00	6	Psychiatric diagnostic eval
90791	U8	$35.00	6	Psychiatric diagnostic eval - home
90832		$30.00	1	Individual therapy – 30 mins.
90832	U8	$35.00	1	Individual therapy – home – 30 mins.
90834		$60.00	1	Individual therapy – 45 mins.
90834	U8	$70.00	1	Individual therapy – home – 45 mins..
90846		$30.00	2	Family therapy without patient present
90846	U8	$35.00	2	Family therapy without patient present - home
90847		$30.00	2	Family therapy with patient present
90847	U8	$35.00	2	Family therapy with patient present - home
90853		$12.50	3	Group therapy (other than multi-family)
90839		$60.00	6	Psychotherapy for Crisis – 60 mins.
90839	U8	$65.00	6	Psychotherapy for Crisis – home – 60 mins.
90880		$8.00	1	Hypnotherapy
90885		$24.00	1	Psychiatric eval of records-inpatient only
96101		$60.00	4	Psychological test by professional
96101	U8	$60.00	4	Psychological test by professional – home
96103		$20.00	4	Psychological test by computer
96103	U8	$20.00	4	Psychological test by computer-home
96105		$35.00	1	Assessment of Aphasia
96111		$35.00	1	Developmental testing
96116		$35.00	1	Neurobehavior status exam
99406**		$8.00	1	Smoking behavior change 3-10 mins.
99407**		$12.00	1	Smoking behavior change over 10 mins.

PSYCHIATRISTS, PSYCHIATRIC CLINICAL NURSES, FQHC, PSYCHIATRIC MENTAL HEALTH NURSE PRACTITIONERS AND RHC

Procedure Code	Modifier	Maximum Allowed	Maximum Quantity	Description
90791		$90.08	6	Psychiatric diagnostic evaluation
90791	U8	$95.08	6	Psychiatric diagnostic evaluation - home
90792		$90.08	6	Psychiatric diagnostic evaluation with medical services
90792	U8	$95.08	6	Psychiatric diagnostic evaluation with medical services – home
90832*		$41.86	1	Individual therapy – 30 mins.
90832*	U8	$43.86	1	Individual therapy – home – 30 mins.
90834*		$71.50	1	Individual therapy – 45mins.
90834*	U8	$81.50	1	Individual therapy – home – 45 mins.
90846		$52.30	2	Family therapy without patient present
90846	U8	$57.30	2	Family therapy without patient present – home
90847		$65.12	2	Family therapy with patient present
90847	U8	$70.12	2	Family therapy with patient present – home
90853		$18.45	3	Group therapy (other than multi-family)
90839		$60.00	6	Psychotherapy for Crisis – 60 mins.
90839	U8	$65.00	6	Psychotherapy for Crisis – home – 60 mins.
90865		$90.66	1	Narcosynthesis
90870		$83.79	1	Electroconvulsive therapy
90880		$65.30	1	Hypnotherapy
90885		$24.00	1	Psychiatric evaluation of records – inpatient only
96101		$66.00	4	Psychological test by professional
96101	U8	$66.00	4	Psychological test by professional – home
96103		$23.76	4	Psychological test by computer
96103	U8	$23.76	4	Psychological test by computer - home
96105		$42.86	1	Assessment of Aphasia
96111		$78.33	1	Developmental testing
96116		$58.59	1	Neurobehavior status exam
99406**		$8.00	1	Smoking behavior change 3-10 mins.
99407**		$12.00	1	Smoking behavior change over 10 mins.

The U8 Modifier is the only appropriate modifier and must be used when submitting claims for place of service 12 (home).

When multiple services are rendered on the same day by the same performing provider an NCCI modifier is required on the second service. The NCCI modifier is in addition to the specialty modifier and, when appropriate, the U8 modifier. Providers should reference the Fee Schedule link on the MHD Web site for a list of NCCI modifiers and use the appropriate modifier for billing.

- * Psychiatrists and/or nurses should utilize *either* the appropriate Evaluation and Management (E & M) code *or* the appropriate psychotherapy code listed above. The billing of a combination of Psychotherapy and E & M code will not be allowed. Please refer to the fee schedule for E & M reimbursement amounts.

- ** MO HealthNet will cover two (2) quit attempts of up to 12 weeks of intervention per lifetime, including behavioral and pharmacologic interventions.

- **PHARMACOLOGIC MANAGEMENT:** MHD will allow the utilization of the appropriate E & M code when pharmacologic management is provided. Providers will have to include all components associated with the appropriate E & M code including documentation that supports the service.

Providers must use the appropriate procedure code when billing for testing, 96101 or 96103.

Psychological Testing may NOT be performed by an LCSW, LMSW, PLPC or LPC.

Psychological Testing administered by a technician (96102) is NOT a covered service.

Neuropsychological Testing (96118, 96119, and 96120) are NOT covered services.

PRIOR AUTHORIZATION

NOTICE: When Behavioral Health Services are rendered through any type of group practice and the group National Provider Identifier (NPI) is used as the billing provider, the group is considered the provider and not each individual in the group.

Psychologist, Psychiatrist, PMHNP, PCNS, RHC, FQHC

ADULTS

Prior Authorization (PA) approves the medical necessity of the requested service and does not guarantee payment. The patient must meet eligibility requirements and the provider must be enrolled and eligible to bill the services.

Many Behavioral Health Services provided to adults (21 years of age or older) must be prior authorized when performed by a Psychiatrist, Provisional Licensed Psychologist, Psychologist, PCNS, PMHNP, Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC).

Independent PLCSWs, LCSWs, PLPCs, and LPCs may not see adults and should not request prior authorization for Behavioral Health Services for clients 21 years of age or older. (NOTE: Independent refers to providers in a private practice as well as those in a non-FQHC or non-RHC group or clinic practice.)

LCSWs and PLCSWs who are members of an FQHC or RHC may provide adult services as part of the clinic. These services will require prior authorization but the request is made using the facility NPI. PLPCs and LPCs may not see adults in any setting.

Family Therapy without the Patient Present requires prior authorization for any age participant including adults.

CHILDREN

PA is required for children, 0 through 20 years of age, who are not in state custody or residing in a residential treatment facility.

PA is required for children, 0 through 20 years of age, who are in state custody with an ME code of 07, 08, 37, 38, who are not residing in a residential treatment facility.

The PA process for children in state custody with other ME codes or residing in a residential treatment facility may be implemented at a later date. Providers will be notified via bulletins regarding change in PA requirements for these state custody children.

PA is required for non-state custody and state custody children when services are provided by a Psychiatrist, Provisional Licensed Psychologist, Psychologist, PCNS, PLCSW, PMHNP, LCSW, LMSW, PLPC, LPC, RHC, or FQHC.

Codes Requiring PA – Provisional Licensed Psychologist, Psychologist, Psychiatrist, PMHNP, PCNS, RHC, and FQHC

ADULTS AND CHILDREN

ALL Behavioral Health services for children under the age of three (3), **regardless of placement / ME code** with the exception of Assessment

Individual Therapy – 90832 (30 minute session)
Individual Therapy – 90834 (45 minute session)
> Maximum of 1 unit, either 30 minute or 45 minute session per day;
> Maximum of 5 units, any combination of 30 minute or 45 minute sessions per month

Family Therapy – 90846 / 90847 (30 minute unit)
> Maximum of 2 units per procedure per day;
> Maximum of 10 units per month

Group Therapy – 90853 (30 minute unit)
> Maximum of 3 units per day;
> Maximum of 15 units per month

Hypnotherapy - 90880 (no time frame noted)

The three codes below only require a PA for children under the age of three (3):

Aphasia Assessment – 96105 (60 minute session)

Developmental testing – 96111 (60 minute session)

Neurobehavioral testing – 96116 60 minute session)

The AH modifier must be included when billing claims for Provisional Licensed Psychologist or Psychologists.

Codes Not Requiring PA – Provisional Licensed Psychologist, Psychologist, Psychiatrist, PMHNP, PCNS, RHC and FQHC

Assessment – 90791 / 90792 (30 minute session)
    Maximum of 6 units per rolling year

Testing – 96101 / 96103 (60 minute session)
    Maximum of 4 sessions per rolling year

Psychotherapy for Crisis – 90839 (60 minute session)
    Maximum of 6 sessions per calendar year

Evaluation Inpatient Hospital Records – 90885 (no time frame noted)

Evaluation and Management codes

The below codes do not require PA for children 3 (three) years of age or older or for adults. **PA is required for children less than 3 (three) years of age.**

Aphasia Assessment – 96105 (60 minute session)

Developmental testing – 96111 (60 minute session)

Neurobehavioral testing – 96116 (60 minute session

Regardless of Prior Authorization, providers are required to adhere to the maximum daily and monthly unit limitations and all other program restrictions. Units over the daily and monthly limits will not be reimbursed.

Codes Requiring PA – PLCSW, LCSW, PLPC, LPC

CHILDREN

All Behavioral Health services for children under the age of three (3), **regardless of placement / ME code** with the exception of Assessment

Individual Therapy – 90832 (30 minute session)
Individual Therapy – 90834 (45 minute session)
    Maximum of 1 unit, either 30 minute or 45 minute session per day;
    Maximum of 5 units, any combination of 30 minute or 45 minute
      sessions per month

Family Therapy – 90846 / 90847 (30 minute session)
    Maximum of 2 units per procedure per day;
    Maximum of 10 units per month

Group Therapy – 90853 (30 minute session)
    Maximum of 3 units per day;
    Maximum of 15 units per month

Codes Not Requiring PA – PLCSW, LCSW, PLPC, LPC

Assessment – 90791 / 90792 (30 minute session)
    Maximum of 6 units per rolling year

Psychotherapy for Crisis – 90839 (60 minute session)
    Maximum of 6 sessions per calendar year.

Regardless of Prior Authorization, providers are required to adhere to the maximum daily and monthly unit limitations and all other program restrictions. Units over the daily and monthly limits will not be reimbursed.

ALL PROVIDERS

Testing and Diagnostic Evaluation (90791 or 90792) do not require PA for most participants.

Testing is limited to independent Psychiatrists, PCNS, PMHNP, Provisional Licensed Psychologist and Psychologists and those providing services through an RHC or FQHC. MO HealthNet does not reimburse for testing when performed by an LPC, PLPC, LCSW, LMSW or regardless of the setting.

PA is required for participants residing in a nursing home but the Behavioral Health services may not be provided at the nursing home. Psychiatrists, PMHNP and PCNS may provide a Diagnostic Evaluation, 90791 or 90792 in the nursing home setting in addition to the appropriate NH visit code for evaluation of pharmacologics.

PA is required for Behavioral Health services provided on public school district grounds when billing to MO HealthNet. Services are billed under the school district MO HealthNet provider NPI with the individual NPI listed as the performing provider.

Providers may only bill for services they personally provide. MO HealthNet does not cover services provided by someone other than the enrolled provider. Services provided by an individual under the direction or supervision of an enrolled provider may not be billed under the supervisor's NPI.

With the exception of Assessment, Behavioral Health services for all children under the age of three (3), including those in state custody and

residential care facilities continue to require Prior Authorization. This includes Testing.

DEFINITIONS

Psychotherapy for Crisis

The definition of Psychotherapy for Crisis is: "A face-to-face contact to diffuse a situation of immediate crisis. The situation must be of significant severity to pose a threat to the patient's well being or is a danger to him/herself or others". Psychotherapy for Crisis services cannot be scheduled nor can they be prior authorized.

Family Therapy
Family therapy is the treatment of the members of a family together, parent(s) and child(ren) rather than an individual "patient". The family unit is viewed as a social system that affects all its members. A parental figure must be present to be considered Family Therapy. (Refer to Section 4.3)

Group Therapy
Group Therapy uses group dynamics and peer interactions to increase understanding and improve social skills. Group therapy is a medically necessary, time-limited, goal-specific, face-to-face interaction based upon planned interventions documented in the Treatment Plan. Groups are limited to a minimum of three (3) but no more than ten (10) patients.

GUIDELINES - Adults

Behavioral health services for adults are authorized on a calendar year with new PAs being authorized beginning January 01 and closing December 31.

Independent PLCSWs, LCSWs, PLPCs, and LPCs may not see adults and should not request PA for Behavioral Health services for clients 21 year of age or older. (NOTE: Independent refers to providers in private practice as well as those in a non-FQHC or non-RHC group or clinic practice.)

LCSWs and PLCSWs who are members of an FQHC or RHC may provide adult services as part of the clinic. These services will require PA but the request is made using the facility provider number. PLPCs and LPCs may not see adults in any setting.

The first four (4) hours of Behavioral Health services for adults do not require PA. These four (4) hours are intended to assist a provider seeing a patient for the first time make the transition to PA should more than four (4) hours be required for treatment. The first four (4) hours are per patient, per **billing** provider, and may

include any combination of Individual Therapy, Family Therapy, or Group Therapy. Providers are not able to deliver four (4) non-PA hours of each type of therapy. These four (4) non-prior authorized hours do not include Family Therapy without the Patient Present. All hours of Family Therapy without the Patient Present must be prior authorized before rendering services. Claims for the four (4) non-PA hours should be submitted and payment established prior to submitting claims for any PA hours.

Providers who have rendered therapy services to a participant within the past 12 months will be considered as having used their four (4) non-PA hours. There must be a minimum of 365 days since the provider last rendered services to the participant before the four (4) non-PA hours may again be used.

After the initial 4 hours, when it is determined that ongoing services are medically necessary, PA must be obtained. This PA must be requested before rendering additional services. In order not to interrupt services it would be best to request authorization before all 4 hours are used.

Behavioral Health services will be covered if they are determined medically necessary when using the diagnostic criteria of the current edition of the DSM. PA approval is based on the DSM diagnosis code. However, the diagnosis code on a submitted claim must be the appropriate diagnosis code from the current edition of the ICD code book.

The authorized number of hours is based on the primary diagnosis and the documentation must support the diagnosis code. Providers are urged to choose the most accurate and appropriate diagnosis code to receive the maximum hours allowed through the PA process.

Up to ten (10) hours of Individual, Family, or Group Therapy or a combination of these will be authorized initially for a covered diagnosis of Adjustment Disorder, V-codes, or NOS codes. The intent is to limit any PA to no more than ten (10) hours for these diagnosis codes for any participant regardless of the provider.

Up to twenty (20) hours will be authorized initially for Individual and Family Therapy or a combination of both for all other covered diagnosis codes based upon provider request, participant need and documentation in the treatment plan. The intent is to limit the first PA to no more than twenty (20) hours of Individual or Family Therapy in any combination for any participant regardless of provider.

Based upon provider request, up to twenty (20) hours of Group Therapy may be authorized in addition to the Individual and Family request outlined above. The intent is to limit the first PA to no more than twenty (20) hours of group therapy for any participant regardless of provider.

An additional ten (10) hours of Individual, Family or Group Therapy or any combination may be requested based upon documentation of patient need. PAs for continued treatment (authorizations beyond the initial approved hours) will be based upon review of clinical documentation to include:

- <u>Psychology/Counseling</u> Services Request for Prior Authorization form
- Current Diagnostic Assessment
- Current/Updated Treatment Plan
- Three (3) Progress Notes reflective of therapy type requested (i.e. requests for additional Family Therapy should include Progress Notes from the three most recent Family Therapy sessions attended by the patient)

PAs for continued treatment will **not** be issued for diagnosis codes including Adjustment Disorder, V codes, or NOS codes.

All documentation submitted must meet the requirements as stated in 13 CSR 70-98-015. Requests submitted with non-compliant documentation as outlined above will result in denial of the request.

The MHD recognizes there are rare instances were Behavioral Health services may be authorized beyond the limits outlined above. For those persons requiring more than the thirty (30) hours of Individual, Family or Group Therapy per year, as discussed above, Clinical Exceptions may be granted based upon documentation of extenuating circumstances.

<u>GUIDELINES – Non-State Custody Children</u>

The MO HealthNet Division (MHD) has made PA requirement changes for Behavioral Health services for children. Current policy and new policy changes are outlined below. Services for non-state custody children are authorized on a rolling year with new PAs beginning August 01 and closing July 31.

With the exception of Assessment, any therapy services, including Testing, for a child under the age of three (3), performed by any MO HealthNet enrolled provider, must be prior authorized. Assessment no longer requires PA for a child under the age of 3. **This age group does not get the 4 non-PA hours.**

Individual therapy and Family Therapy without the Patient Present require PA when provided by any MO HealthNet enrolled provider, **regardless of the age of the patient. These services will not get the 4 non-PA hours.**

Requests for PA for these services may be faxed or mailed with the documentation. They will not be authorized by a phone call. The documentation must include the PA request form, the current Diagnostic Evaluation, current

Treatment Plan and the last three (3) Progress Notes. A PA request for any service for a child under the age of three (3) **must** include clinical justification.

When requesting PA Behavioral Health services will be covered if they are determined medically necessary when using the diagnostic criteria in the current edition of the DSM. However, the diagnosis code on a submitted claim must be the appropriate diagnosis in the current edition of the ICD diagnosis code book.

Testing services are not covered when provided by a PLCSW, LCSW. PLPC or LPC regardless of the age of the client.

When requesting PA for services for children under the age of three (3) and Family Therapy without the Patient Present the PA Form, current Diagnostic Evaluation, current Treatment Plan, and the last three (3) Progress Notes be mailed or faxed.

PA has always been required for Individual Therapy, Family Therapy with the Patient Present, and Group Therapy for children under the age of three (3) when services are provided by an LCSW, LPC, PLCSW, LMSW, PLPC, RHC, FQHC, psychologist, provisionally licensed psychologist, or psychiatrist. This policy remains in effect.

Prior Authorization Policy for Children 0 through 20

The MO HealthNet Division has a prior authorization process for all children birth (0) through 20 who are not in state custody or residing in a residential treatment facility.

The PA process includes services provided by a Psychiatrist, Provisional Licensed Psychologist, Psychologist, PCNS, PLCSW, LCSW, LMSW, PLPC, LPC, RHC, and FQHC.

The first four (4) hours of Behavioral Health services for most children and services do not require PA. These four (4) hours are intended to assist a provider seeing a patient for the first time make the transition to PA should more than four (4) hours be required for treatment. The first four (4) hours are per patient, per provider, and may include any combination of Individual Therapy, Family Therapy, or Group Therapy. Providers are not able to deliver four (4) non-PA hours of each type of therapy. Claims for the four (4) non-PA hours should be submitted and payment established prior to submitting claims for any PA hours.

Providers who have rendered therapy services to a participant within the past 12 months will be considered as having used their four (4) non-PA hours. There must be a minimum of 365 days since the provider last rendered services to the participant before the four (4) non-PA'd hours may again be used.

A change in the child's ME code from non-state custody to a state custody code of 07, 08, 37, or 38 does not allow a provider an additional four (4) non-PA hours.

This does <u>not</u> apply if providing services to children under the age of 3 or Family Therapy without the Patient Present. All hours of these services <u>must</u> be prior authorized, regardless of placement and ME code.

After the initial 4 hours, when it is determined that ongoing services are medically necessary, PA must be obtained. This PA must be requested <u>before</u> rendering additional services. In order not to interrupt services it would be best to request authorization before all 4 hours are used.

PA for Behavioral Health services for children is based on the age of the child and the type of therapy requested. Based on these limitations the first request for PA can include Individual, Family, and Group Therapy.

Testing for a child under the age of 3 must be prior authorized and providers must submit clinical justification for providing these services. PA does not allow the provider to exceed the unit limitations for these services.

Approved hours will be based on the current edition of the DSM diagnosis code. Up to ten (10) hours of Individual Therapy will be allowed for a diagnosis of Adjustment Disorder, V-codes, or NOS codes. All other diagnosis codes will be authorized hours based on age and type of therapy being requested. The authorized number of hours is based on the primary diagnosis and documentation must support the diagnosis code. Providers are urged to choose the most accurate and appropriate diagnosis code to receive the maximum hours allowed through the PA process.

Children are best treated within the environment in which they live. Clinical evidence suggests family intervention is superior to individual therapy in treating children with many behavioral health disorders. Therefore, treatment should support the child within the family whenever possible. Clinical evidence also suggests treatment must be based upon age and cognitive development of the child. Best practice approaches should insure the coordination of care when multiple providers are involved with the same child/family.

Group therapy uses group dynamics and peer interactions to increase understanding and improve social skills.

Multiple therapies are the treatment of the individual with more than one therapy such as Individual and Family, simultaneously within the same authorization period. The treatment plan must document the medical need for more than one therapy. There is no procedure code that specifies multiple therapies are being requested.

If a child's age changes during the PA period, the PA will continue as authorized. However, if the child turns 21 during the authorization period, the policy on age restriction for certain providers will apply. LPCs and LCSWs who are restricted to seeing children under the age of 21 will not be paid for services performed on or after the date the child reaches the age of 21 even if prior authorized.

Prior Authorization by Age Group

Behavioral Health services for children under the age of 3 and Family Therapy without the Patient Present will not be allowed under the 4 hours of non-PA service. The preferred method of treatment is indicated first and if no documentation is required a telephone call may be made to request PA.

PRIOR AUTHORIZATION LIMITATIONS BY AGE GROUP
Children Age Birth through 2 Years

Testing for a child under the age of three (3) years *must* be prior authorized and providers *must* submit clinical justification for providing these services. Children, birth through two (2) years of age, are not allowed the four (4) hours of non-PA'd services.

- Family Therapy will be authorized initially up to twenty (20) hours based upon the submission of required clinical documentation.

- Individual Therapy will not be authorized.

- Group Therapy will not be authorized.

Children Age 3 Years

- Family Therapy will be authorized initially for up to five (5) hours **without** submitting documentation.

- Family Therapy may be reauthorized up to fifteen (15) hours based upon the submission of required clinical documentation.

- Individual Therapy may be authorized for up to ten (10) hours based upon the submission of required clinical documentation.

- Group Therapy will not be authorized.

Children Age 4 Years

- Family Therapy will be authorized initially for up to five (5) hours **without** submitting documentation.

- Family Therapy may be reauthorized up to fifteen (15) hours based upon submission of required clinical documentation.

- Individual Therapy will be authorized initially for up to five (5) hours **without** submitting documentation.

- Individual Therapy may be reauthorized for up to ten (10) hours based upon the submission of required documentation.

- Group Therapy will not be authorized.

Children Age 5 through 12 Years

- Family Therapy will be authorized initially for up to twenty (20) hours **without** submitting documentation.

- Family Therapy may be reauthorized for up to twenty (20) hours based upon the submission of required clinical documentation.

- Individual Therapy will be authorized initially for up to five (5) hours **without** submitting documentation.

- Individual Therapy may be reauthorized for up to ten (10) hours based upon submission of required documentation.

- Group Therapy will be authorized initially for up to five (5) hours **without** submitting documentation.

- Group Therapy may be reauthorized for up to ten (10) hours based upon submission of required documentation.

Children Age 13 through 17 Years

- Individual or Family Therapy or a combination of both will be authorized initially for up to twenty-five (25) hours **without** submitting documentation.

- Individual or Family Therapy or a combination of both may be reauthorized for up to thirty (30) hours based upon the submission of required documentation.

- Group Therapy will be authorized initially for up to five (5) hours **without** submitting documentation.

- Group Therapy may be reauthorized for up to ten (10) hours based upon submission of required clinical documentation.

Children Age 18 through 20 Years

- Individual Therapy will be authorized initially for up to twenty (20) hours **without** submitting documentation.

- Individual Therapy may be reauthorized for up to twenty (20) hours based upon the submission of required clinical documentation

- Family Therapy will be authorized initially for up to five (5) hours **without** submitting documentation.

- Family Therapy may be reauthorized for up to ten (10) hours based upon submission of required documentation.

- Group Therapy will be authorized initially for up to five (5) hours **without** submitting documentation.

- Group Therapy may be reauthorized for up to ten (10) hours based upon submission of required documentation.

The MO HealthNet Division recognizes that there are rare instances in which Behavioral Health services may be required beyond the limits outlined above. For those patients who require additional therapy, a Clinical Exception may be requested based upon documentation of extenuating circumstances. Providers may contact the Behavioral Health Services Help Desk (866-771-3350) for additional information on requesting a Clinical Exception.

GUIDELINES – State Custody Children
State Custody MO HealthNet Eligibility (ME) Codes

Prior Authorization is required for children in state custody with an ME code of 07, 08, 37, or 38, who are not residing in a residential treatment facility. Services for state custody children are authorized on a calendar year with new PAs being authorized beginning January 01 and closing December 31.

Behavioral Health services for a child residing in or under the management of a residential care facility have always been exempt from the PA process when the services were provided at the facility. If the services were rendered off the facility site, a PA was required. Residential care facilities routinely allow children to be seen off site for therapy services. Some children residing in or under the management of a residential care facility are exempt from the PA requirement when therapy services are provided off site. The child must be 3 years of age or older and have an ME code of 07, 08, 37 or 88. If this criteria is not met, a PA is still required when therapy services are provided off the facility site. Providers must work closely with the facility and Children's Division to ensure the child is still residing in or under the management of the residential care facility. Therapy services meeting this criteria are billed with the appropriate place of service code, applicable provider specialty modifier, U8 modifier if necessary, and the NCCI 59 modifier if multiple therapy services are provided on the same day. In addition to these modifiers, when therapy services are provided to a child off site of the residential care facility, a TJ modifier must also be used.

At this time ME codes 29, 30, 35, 36, 50, 51, 52, 53, 54, 56, 57, 63, 64, 66, 68, 69, 70, are exempt from PA requirements due to the child being in state custody. When verifying eligibility, if the ME code is **not** one of these, regardless of other source information, you **must** request PA.

Regardless of the ME code, children under the age of 3 years even in state custody require PA for testing and behavioral health services; Diagnostic Evaluation does not require PA. Children under the age of 3 years in state custody also do not receive the four (4) non-prior authorized hours.

The first four (4) hours of Behavioral Health services do not require PA. The first four (4) hours are per patient, per provider, and may include any combination of Individual Therapy, Family Therapy, or Group Therapy. Providers are not able to deliver four (4) non-PA hours of each type of therapy. Claims for the four (4) non-PA hours should be submitted and payment established prior to submitting claims for any PA hours.

Providers who have rendered therapy services to a participant within the past 12 months will be considered as having used their four (4) non-PA hours. There must be a minimum of 365 days since the provider last rendered services to the participant before the four (4) non-PA hours may again be used.

A change in the child's ME code of 07, 08, 37, 38 from state custody to non- state custody does not allow a provider an additional four (4) non-PA hours.

If a child's age changes during the PA period, the PA will continue as authorized. However, if the child turns 21 during the authorization period, the policy on age restriction for certain providers will apply. LPCs and LCSWs who are restricted to seeing children under the age of 21 will not be paid for services performed on or after the date the child reaches the age of 21 even if prior authorized.

Family Therapy without the Patient Present and all Behavioral Health services for patients age birth through 2 years are **not** included in the four (4) non-PA hours. These services continue to require PA regardless of ME code or placement.

If more than the four (4) non-PA hours are needed, a PA must be obtained. The PA must be obtained prior to rendering the services. In order to insure continuity of service, providers should request a PA before all of the first four (4) hours are used.

The authorized number of hours is based on the primary diagnosis and your documentation must support the diagnosis code. Providers are urged to choose the most accurate and appropriate diagnosis code to receive the maximum hours allowed through the PA process.

PAs for Behavioral Health services for children are issued for a maximum of ten (10) hours for Adjustment Disorder, V-codes, or NOS codes.

Guidelines for the hours issued for all other covered diagnosis codes are indicated by age group below.

PRIOR AUTHORIZATION GUIDELINES BY AGE GROUP AND HOURS ASSIGNED

*0 – 2 YEAR OLDS – ALL REQUIRE PA/CLINICAL REVIEW

- 10 Family Therapy (FT) with clinical review

- 20 reauthorization with clinical review

- 20 reauthorization with clinical review

*3 YEAR OLDS

- 10 FT without (w/o) submitting documentation

- 15 FT reauthorization with documentation

- 15 FT reauthorization with documentation

- 5 IT with clinical review

- 10 IT reauthorization with clinical review

- Group therapy (GT) is not allowed for this age group

*4 YEAR OLDS

- 10 FT w/o submitting documentation

- 15 FT reauthorization with documentation

- 15 FT reauthorization with documentation

- 5 IT w/o documentation

- 15 IT reauthorization with documentation

- 15 IT reauthorization with documentation

- Group therapy is not allowed for 4 year olds.

*5-20 YEAR OLDS

- 10 FT w/o submitting documentation

- 15 FT reauthorization with documentation

- 15 FT reauthorization with documentation

- 10 IT w/o documentation

- 15 IT reauthorization with documentation

- 15 IT reauthorization with documentation

- 10 GT w/o documentation

- 15 GT reauthorization with documentation

- 15 GT reauthorization with documentation

MHD recognizes there are rare instances where Behavioral Health services may be needed beyond the guidelines outlined above. For those persons requiring more therapy than what is allowed under the above guidelines, Clinical Exceptions may be granted based upon documentation of extenuating circumstances. Providers requesting Clinical Exceptions may contact the Behavioral Health Services Help Desk at (866) 771-3350.

REQUESTING PRIOR AUTHORIZATION

Providers may deliver four (4) hours of Behavioral Health services without PA to a participant they have not provided treatment to within the last rolling year. The four (4) hours are intended to assist a provider seeing a participant for the first time in making the transition to PA should more than four (4) hours be required for treatment. Providers who have been paid for services in excess of four (4) hours for a participant in the last year will not receive four (4) non-PA hours for that participant.

Family Therapy without the Patient Present and all Behavioral Health therapy services for participants age 0 through 2 years are not included in the four (4) non-PA hours and continue to require PA.

The claims for the four (4) non-PA hours should be submitted and payment established prior to submitting claims for any prior authorized hours/services.

If services are required beyond the initial four (4) non-PA hours, the provider must request a PA. To request an initial PA you or a staff member may call (866) 771-3350. Although not mandatory, you should complete the Psychology/Counseling Services Request for Prior Authorization form as the information on this form will be required to complete the request for services. Telephoned requests will receive an approval or denial at the time of the call. (**If additional information is needed, the caller will be instructed to fax or mail the PA form and required documentation. This PA request will not be approved during the phone call.**

To request continuing services beyond the initial authorization, the Psychology/Counseling Services Request for Prior Authorization form must be completed and submitted along with the (1) current Treatment Plan, (2) current Diagnostic Evaluation and (3) copies of the last three (3) Progress Notes reflecting the therapy type being requested. If the services being requested are court ordered, a copy of the court order must also be attached.

This documentation may be faxed to: **(573) 635-6516**

or mailed to: MO HealthNet Division
               PO Box 4800
               Jefferson City, MO 6510

If less than ten (10) hours was originally authorized 40% of the hours must be used before requesting additional hours. If ten (10) or more hours are authorized 75% of the hours must be before requesting additional hours. The PA approves the delivery of the requested services only and does not guarantee payment. The PA must be obtained prior to delivery of services. The participant must meet eligibility requirements on the date the service is provided and the provider must be enrolled and eligible to bill for the services.

Family Therapy without the Patient Present will require the PA Form, current Diagnostic Evaluation, current Treatment Plan, and the last three (3) Progress Notes may be mailed or faxed.

For children 12 years of age and younger current documentation is six (6) months old or less. For children 13 years of age and older, as well as adults, current documentation is one (1) year old or less.

Providers will not receive a disposition letter when services are authorized or denied via a phone call. An authorization number will be provided. Services that require submission of the PA form and attachments will receive a disposition letter after review. When PA requests are denied partially or in full, the client will receive a letter outlining the reason for denial and their appeal rights. **Do not give participants the provider Prior Authorization Request telephone number or fax number. Their contact information will be listed in their denial letter.**

If the participant is changing providers, the provider listed on the current PA must end that PA before the new provider can be issued a PA. If the current provider refuses to close the PA, the new provider must submit a signed release from the client, requesting a change in provider, in order to close the current PA. The signed release must include the participant name, DCN, type of therapy to be closed and the name of the therapist whose authorization is to be closed.

If a provider needs to change a PA, the provider may call or fax in the information to request a change. The participant name, DCN, type of therapy, what the current PA says, and the requested change must be indicated.

When a client changes providers documentation is required to authorize a new PA. The new provider will be authorized any balance of unused hours on the original PA, not receive an additional 10 or 20 hours for therapy. The intent is to limit therapy services for any participant regardless of provider. However, Clinical Exceptions may be granted based upon documentation of extenuating circumstances.

A client may have an open PA with one provider for Individual Therapy and/or Family Therapy and a second PA open with the same or different provider for Group Therapy. **Only one Family Therapy PA per family will be open at a time.**

Do not request overlapping dates from a previous PA; overlapping dates will cause the new PA request to deny. Do not indicate the four (4) non-PA hours as used hours on the PA request.

Individual providers that are not seeing a participant through an RHC, FQHC, or other clinic/group must request a PA using their individual NPI. Providers seeing participants in an FQHC or other clinic/group setting must request a PA using the FQHC clinic/group NPI. Providers seeing participants in a RHC setting must use the RHC NPI when requesting a PA.

PA is required even when there is coverage through a third party insurance (i.e. Blue Cross/Blue Shield; Prudential). Medicare is not considered third party insurance; however, if there is no PA and Medicare does not cover the service, MO HealthNet cannot pay.

PA is required for clients residing in a nursing home but Behavioral Health services may not be provided at the nursing home. These services must be provided off the nursing home grounds.

Providers may only bill for services they personally provide. MO HealthNet does not cover services provided by someone other than the enrolled provider. Services provided by an individual under the direction or supervision of an enrolled provider are not covered.

With the exception of Diagnostic Evaluation, all services for all children under the age of three (3), including those in state custody and residential care facilities, continue to require PA. This includes Testing.

Prior Authorization Exceptions

Inpatient hospital stays

Psychotherapy for Crisis

Testing

Diagnostic Evaluation

Evaluation and Management codes

Narcosynthesis

Electroconvulsive Therapy

Medicare primary

Providers are reminded that a PA request cannot be processed if the participant or provider identifying information is incomplete or inaccurate (including provider NPI, DCN, etc.). Every attempt is made to reconcile any incorrect/inaccurate information with providers; however, it remains the provider's responsibility to provide complete and accurate information when submitting a request for PA. Authorizations are approved effective the date all completed correct information and documentation is received.

DOCUMENTATION REQUIREMENTS
All services provided must be adequately documented in the medical record. The requirement to document services and to release records to representatives of the Department of Social Services or the U.S. Department of Health and Human Services is stated in MO HealthNet state regulation (13 CSR 70-3) Conditions of Provider Participation, Reimbursement and Procedure of General Applicability. These requirements are also repeated in the Title XIX Participation Agreement, which is a document signed by all providers upon enrollment as a MO HealthNet provider. More detailed information of the documentation requirements can be found in the Behavior Health Services Manual, section 13.4. This information can also be found in the Behavioral Health Services billing book, Section 4.

PARTICIPANT APPEAL RIGHTS
When a request is denied, the participant will receive a letter which outlines the reason for the denial and the procedure for appeal. The State Fair Hearings Process may be requested by the participant, in writing, to the MO HealthNet Division, Participant Services Unit (PSU), P.O. Box 3535, Jefferson City, MO 65102-3535. The Participant Services Unit may also be called toll free at 1-800-392-2161 or 573-751-6527 at the caller's expense. The participant must contact PSU within 90 days of the date of the denial letter if they wish to request a hearing. After 90 days, requests to appeal are denied.

Prior Authorization Tips

Testing and other Behavioral Health services for children under the age of 3 years always require PA and clinical justification. Diagnostic Evaluation no longer requires PA.

Documentation is required for continuing therapy. The required documentation is the current Diagnostic Assessment, current Treatment Plan, and the last 3 Progress Notes. If the Behavioral Health services being requested are court ordered, a copy of the court order must also be attached to the documentation

Only one Family Therapy PA per family will be open at a time.

Call for approval on an initial PA when the service does not require documentation.

When a PA request has been faxed or mailed allow sufficient time for the request to be reviewed. Do not send duplicate requests; expect at least five (5) days for a reply. You may call the following number to check on the status of a PA request:

Provider Communication (573) 751-2896

When faxing PA requests only send one (1) at a time. Multiple requests on the same fax must be handled differently and result in additional delay in response. Please do not fax questions to the Behavioral Health Services Help Desk. Send questions by email to Ask.MHD@dss.mo.gov.

Review the documentation requirements to insure all aspects have been included, are easily identified, and that appropriate documentation is being submitted with your PA request.

If a child's age changes during the authorization period, the PA will continue as authorized. **BUT** if the child turns 21 during the authorization period the policy for age restrictions will still apply even when services are prior authorized.

PA requests will not be backdated. Allow sufficient time for submission and review of the PA and documentation. This includes enough time to resubmit the PA and documentation in the event the first submission is denied.

Daily and monthly limitations still apply even though an authorization has been approved.

The FQHC, RHC, clinic, or group is considered the provider. The FQHC, RHC, clinic, or group receives the 4 non-PA hours as well as testing and assessment time, not each individual within these group settings.

SECTION 6
ADJUSTMENTS

Providers who are paid incorrectly for a claim should submit an individual adjustment via the Infocrossing Internet service, www.emomed.com, Adjustments may not be requested when the net difference in payment is less than $4.00, or $.25 for pharmacy, per claim. If the adjustment is due to an insurance payment, or involves Medicare, the $4.00, or $.25, minimum limitation does not apply.

Adjustments for claim credits submitted via the Internet get a confirmation back the next day after submission to confirm the acceptance and indicate the status of the adjustment. If the Internal Control Number (ICN) on the credit adjustment is not valid, the confirmation file indicates such. If no confirmation is received, the provider should resubmit the claim credit.

See Section 4 of the MO HealthNet *Provider Manual* for timely filing requirements for adjustments and claim resubmissions.

CLAIM RESUBMISSION ON EMOMED.COM

Emomed.com has been enhanced to assist in the claims resubmission process. An automated claim retrieval process is now in place to automatically populate the claim form fields on emomed.com. A claim may be retrieved using the 'View Claim Status' function or the 'Claim Confirmation' options on emomed.com.

IMPORTANT TIPS TO CONSIDER:
Usage of the Claim Frequency Type Code field (which is now a required field)

1 – ORIGINAL – should be used to create a new claim, or if the original claim submitted
    has a denied claim status (claim status K or N).

7 – REPLACEMENT – should be used if the original claim was submitted incorrectly
    and needs to be replaced with a corrected claim on the MO HealthNet system.

8 – VOID – should be used if a claim is to be credited , recouped or reversed
    completely from the MO HealthNet system.

USING 'VIEW CLAIM STATUS' OPTION TO RESUBMIT A CLAIM
 1. Click on 'View Claim Status' on the Home page of emomed.com.
 2. Enter the claim criteria that you wish to inquire.
 3. Select the correct claim that you wish to resubmit from the 'Claim Status Selection'
     screen.
 4. The 'View Claim' button will display the claim detail information on the claim status
     response screen.
 5. The 'Resubmit' button will link to the populated claim form screen.

6. Edit the claim with the corrected claim information. Some fields may be slightly different than originally submitted, so please review all claim information.
7. Review any attachments (TPL Other Payers, Certificate of Medical Necessity, etc.) and verify that the information is correct.
8. Submit the correct claim.
9. Review the claim confirmation the next business day to verify processing results.

USING THE 'CLAIM CONFIRMATION' OPTION TO RESUBMIT A CLAIM
1. If the claim has been submitted through emomed.com within the last 45 days, you may retrieve the claim from the claim confirmation screen.
2. Click on 'Claim Confirmation' on the Home page of emomed.com.
3. Locate and click on the correct date of the claim confirmation report. (The claim confirmation is dated the next business date after the claim was submitted on emomed.com).
4. Click on the ICN of the claim that is to be resubmitted.
5. Edit the claim with the corrected claim information. Some fields may be slightly different than originally submitted, so please review all claim information.
6. Review any attachments (TPL Other Payers, Certificate of Medical Necessity, etc.) and verify that the information is correct.
7. Submit the corrected claim.
8. Review the claim confirmation the next business day to verify processing results.

For any technical support issues, please contact the Infocrossing Help Desk at (573)635-3559 or via E-mail at internethelpdesk@momed.com.

SECTION 7

MEDICARE BILLING TIPS

CLAIMS NOT CROSSING OVER ELECTRONICALLY

If none of a provider's Medicare claims are crossing over to MO HealthNet electronically, contact MO HealthNet at 573/751-2896 to see if the provider has an NPI on the Medicare file and that it is the correct one. Although Medicare advises that a claim was forwarded to MO HealthNet for processing, this does not guarantee that MO HealthNet received the claim information or was able to process it. If there is a problem with the claim or the participant or provider files, the claim will not process. **A provider should wait 60 days from the date a claim was paid by Medicare before filing a crossover claim with MO HealthNet.** If a claim is submitted sooner, it is possible that the provider will receive a duplicate payment. If this occurs, the provider must submit an Individual Adjustment Request form to have MO HealthNet take back one of the payments.

TIMELY FILING

Claims initially filed with Medicare within Medicare timely filing requirements and that require separate filing of a crossover claim with MO HealthNet must meet the timely filing requirements by being submitted by the provider and received by the MO HealthNet agency within 12 months from the date of service or six months from the date, of the allowed claim, on the provider's Medicare Explanation of Medicare Benefits (EOMB), whichever date is *later*. The counting of the six-month period begins with the date of adjudication of the Medicare payment and ends with the date of receipt.

BILLING FOR ELIGIBLE DAYS

A provider may attempt to bill only for eligible days on the Medicare Part B claim form. In order for crossover claims to process correctly, a provider must bill all dates of service shown on the Medicare EOMB. The MO HealthNet claims system will catch those days' claims containing ineligible days and the claim will be prorated for the eligible days only.

At the MO HealthNet billing Web site, click on 'Medicare CMS 1500 Part B Crossover. That will bring you to the screen above.

> ➢ **Scroll to the bottom of the form and click on the 'Help' button, print off and save the instructions;**
> ➢ **Scroll back to the top of the form and complete all the MO HealthNet header information. Complete the fields as shown above, then complete the Header Other Payer by clicking on 'ADD/EDIT'.**

State of Missouri MO HealthNet

Other Payer Header Information

Enter Other Payer(s) Header Information for Medicare CMS 1500 Part B Crossover claim. Fields marked * must be filled in.

Other Payer #1		
Other Payer ID *	1	
Filing Indicator*	MB-Medicare ▼	**Other Payer Name*** MEDICARE E
Paid Amount $	25.88	**Paid Date (mm/dd/yy)*** 07 / 13 / 07
Header Allowed Amount $ *	32.35	**Total Denied Amount $** 0.00

Group Codes, Reason Codes & Adjustment Amounts					
Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
	▼			▼	
	▼			▼	
Remark Codes					

[Help]

➢ **Now you are on the Other Payer Header screen. Scroll to the bottom of the form and click on the 'Help' button, print off and save the instructions.**
➢ **Scroll back to the top of the form and complete the information at the top as shown. For Part B and Part B of A crossover claims, you do not complete the Group Codes, Reason Codes and Adjustment Amounts information. You will be entering this information elsewhere.**
➢ **Click on 'Done'.**

State of Missouri MO HealthNet

Other Payer Detail Information

Enter Other Payer(s) Detail Information for Medicare CMS 1500 Part B Crossover claim.
Fields marked * must be filled in.

Claim Detail Line #1

Other Payer #1					
Other Payer ID *	1		Paid Date (mm/dd/yy)*	07 / 13 / 07	

Group Codes, Reason Codes & Adjustment Amounts

Group Code		Reason Code	Adjust Amount $	Group Code		Reason Code	Adjust Amount $
CO-Contractual Obligation	▼	045	9.00	PR-Patient Responsibility	▼	002	6.47
PR-Patient Responsibility	▼	122	9.65		▼		

[Help]

- ➢ **Now you are on the Other Payer Detail screen. Scroll to the bottom of the form and click on the 'Help' button, print off and save the instructions.**
- ➢ **Scroll back to the top, complete the Medicare paid date information as well as the Group and Reason Codes and Adjustment Amounts. See above sample. If the reason codes are not listed on your Medicare EOMB, choose the most appropriate code from the list of "Claim Adjustment Reason Codes" from the HIPAA Related Code List. For example, the code on the Claim Adjustment Reason Code list for deductible amount is 1 and for coinsurance amount is 2. Therefore, you would enter a Reason Code of '001' for deductible amounts and '002' for coinsurance amounts due.**
- ➢ **The 'Adjust Amount' should reflect any amount not paid by Medicare including deductible, coinsurance and any non-allowed amounts.**

SECTION 8
RESOURCE PUBLICATIONS FOR PROVIDERS

CURRENT PROCEDURE TERMINOLOGY (CPT)

MO HealthNet uses the latest version of the *Current Procedural Terminology* (CPT). All provider offices should obtain and refer to the CPT book to assure proper coding. Providers can order a CPT book from the American Medical Association.

> Order Department
> American Medical Association
> P.O. Box 7046
> Dover, DE 19903-7046
> Telephone Number: 800/621-8335
> Fax Orders: 312/464-5600

ICD-9-CM

The *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9) is the publication used for proper diagnostic coding. The diagnosis code is a required field on certain claim forms and the accuracy of the code that describes the patient's condition is important. The publication can be ordered from the following source.

> Ingenix Publications
> P.O. Box 27116
> Salt Lake City, UT 84127-0116
> 800/464-3649
> Fax Orders: 801/982-4033
> www.IngenixOnline.com

HEALTH CARE PROCEDURE CODING SYSTEM (HCPCS)

MO HealthNet also uses the *Health Care Procedure Coding System (HCPCS), National Level II*. It is a listing of codes and descriptive terminology used for reporting the provision of supplies, materials, injections and certain services and procedures. The publication can be ordered from the following.

> Practice Management Information Corporation
> 4727 Wilshire Blvd. Ste 300
> Los Angles, CA 90010
> 800/633-7467
> http://pmiconline.com

SECTION 9
RECIPIENT LIABILITY
State Regulation 13CSR 70-4.030

If an enrolled MO HealthNet provider does not want to accept MO HealthNet as payment but instead wants the patient (participant) to be responsible for the payment (be a private pay patient), there must be a written agreement between the patient and the provider in which the patient understands and agrees that MO HealthNet will not be billed for the service(s) and that the patient is fully responsible for the payment for the service(s). The written agreement must be date and service specific and signed and dated both by the patient and the provider. **The agreement must be done prior to the service(s) being rendered.** A copy of the agreement must be kept in the patient's medical record.

If there is no evidence of this written agreement, the provider cannot bill the patient and must submit a claim to MO HealthNet for reimbursement for the covered service(s).

If MO HealthNet denies payment for a service because all policies, rules and regulations of the MO HealthNet program were not followed (e.g., Prior Authorization, Second Surgical Opinion, etc.), the patient is not responsible and cannot be billed for the item or service.

All commercial insurance benefits must be obtained before MO HealthNet is billed.

MO HEALTHNET RECIPIENT REIMBURSEMENT (MMR)

The MO HealthNet Recipient Reimbursement program (MMR) is devised to make payment to those recipients whose eligibility for MO HealthNet benefits has been denied and whose eligibility is subsequently established as a result of an agency hearing decision, a court decision based on an agency hearing decision, or any other legal agency decision rendered on or after January 1, 1986.

Recipients are reimbursed for the payments they made to providers for medical services received between the date of their denial and the date of their subsequent establishment of eligibility. The recipient is furnished with special forms to have completed by the provider(s) of service. If MO HealthNet recipients have any questions, they should call (800) 392-2161.

SECTION 10
<u>FORMS</u>

On the following pages are copies of various forms used by the MO HealthNet
Psychology/Counseling program.

- Go to the MO HealthNet Web site,
  http://www.dss.mo.gov/mhd/providers/index.htm and select and click on "forms"
  under Provider Information.

STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES
PSYCHOLOGICAL SERVICES REQUEST FOR PRIOR AUTHORIZATION

PARTICIPANT NAME (LAST, FIRST, M.I.)	PROVIDER NAME (AFFIX LABEL HERE)	
PARTICIPANT NUMBER	BILLING PROVIDER IDENTIFIER	PROVIDER TAXONOMY CODE (IF REQUIRED)
DATE OF BIRTH	PROVIDER TELEPHONE NUMBER	PROVIDER FAX NUMBER
PROVIDER SIGNATURE		DATE
NUMBER OF HOURS USED ON CURRENT PA*	HOURS USED AS OF (DATE)	

REQUESTED START DATE OF PA

1. Service Requested (If requesting Family Therapy please see reminder in instructions)
   Services that **always** require a PA for all participants:
   Children – Birth through 2 years old
   ☐ Assessment   Hours _____   ☐ Testing   Hours _____   ☐ Therapy - Therapy Type _____ Hours _____
   All Ages
   ☐ Individual Interactive Therapy   Hours _____   ☐ Family Therapy without patient present   Hours _____

Services that require PA per program guidelines:
☐ Individual Therapy   Hours _____   ☐ Family Therapy**   Hours _____   ☐ Group Therapy   Hours _____
☐ Individual and Family Therapy Combination**   Hours Individual _____   Hours Family _____
**If requesting Family Therapy, please list all members of the family, relationship to patient and DCN if available.

2. Has the patient/guardian agreed to his/her treatment plan? ☐ Yes ☐ No
3. Is the therapy court ordered? ☐ Yes ☐ No
4. Have you communicated with other involved therapist/health care practitioner about treatment? ☐ Yes ☐ No
5. If child is in state custody, have you provided a copy of the treatment plan to the Children's Division casemanager or contracted casemanager? If yes, date _____
   Casemanager Name _____ ☐ Child not in state custody ☐ Yes ☐ No
6. Is therapy the result of an EPSDT screen? If yes, date of screen _____ ☐ Yes ☐ No

AXIS I: CLINICAL DISORDERS OR OTHER CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTIONS

DIAGNOSTIC CODE	DIAGNOSTIC CODE

IS THERE EVIDENCE OF SUBSTANCE ABUSE?
☐ Yes   ☐ No

AXIS II: PERSONALITY DISORDERS, MENTAL RETARDATION

DIAGNOSTIC CODE	DIAGNOSTIC CODE

AXIS III: GENERAL MEDICAL CONDITIONS

DOES THIS PATIENT HAVE A CURRENT GENERAL MEDICAL CONDITION THAT IS POTENTIALLY RELEVANT TO THE UNDERSTANDING OR MANAGEMENT OF THE CONDITION(S) NOTED IN AXIS I OR II?
☐ Yes   ☐ No   If Yes, list condition: _____

AXIS IV: PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS (PLEASE INDICATE ALL THAT APPLY)

☐ Problems with primary support group   ☐ Other psychosocial and environmental problems   ☐ Occupational problems
☐ Problems related to social environment   ☐ Problems related to interaction with legal system/crime   ☐ Educational problems
☐ Problems with access to health care   ☐ Economic problems   ☐ Housing problems
☐ None

AXIS V: GLOBAL ASSESSMENT OF FUNCTIONING (CHECK ONE AND LIST SCORE) ☐ MODIFIED GAF AGE 18 AND OLDER ☐ C-GAS AGE 6-17

SCORE	DATE

*Please see instructions on reverse side of form   **Please see instructions on reverse side of form

MO 886-4140 (6-08)

INSTRUCTIONS FOR COMPLETION

HEADER INFORMATION

Participant Name, Number and Date of Birth – Enter the participant's information as it appears on the MO HealthNet ID card.

Provider Name – Enter the provider name.

Billing Provider Identifier – Enter the provider identifier (NPI) that will be used for billing services to MO HealthNet. If this is a clinic/group setting the clinic number should be entered here.

Provider Taxonomy Code – Enter the Taxonomy code (if required)

Provider Telephone Number – Enter current telephone number of the provider making the request.

Provider Fax Number – Enter the fax number of the provider making the request.

Signature/Date – The provider of services should sign the request and indicate the date the form was completed.

*Number of Hours used on current PA – If the current PA was approved for less than 10 hours, a continued treatment request can be made when 40% of the existing PA hours have been used. If the current PA was approved for 10 hours or more, the continued treatment request can be made when 75% of the existing PA hours have been used.

QUESTIONS NUMBER 1 THROUGH 7 MUST BE COMPLETED FOR THERAPIES REQUESTED.

Requested Start Date of PA – Please indicate the date you would like for your PA to begin. NOTE: The authorized start is the date of receipt or noted subsequent date.

Hours requested for Assessment and Diagnostic Testing must be noted in order to be authorized. Individual Interactive Therapy, Family Therapy Without the Patient Present, and all services for children ages birth through 2 years of age require documentation at all times.

**REMINDER: When requesting Family Therapy, please list all members of the family. Only one (1) PA will be approved and open at a time for Family Therapy. If there is more than one eligible child and no child is exclusively identified as the primary patient of treatment, then the oldest child's DCN MUST be used for PA and billing purposes. PROVIDERS SHOULD NOT REQUEST MORE THAN ONE (1) FAMILY THERAPY PRIOR AUTHORIZATION PER FAMILY. Each child may not be seen separately with parents and billed as Family Therapy.

If therapy is the result of a court order a copy should be kept in the patient's file and a copy of the court order should be forwarded along with any continued therapy request.

DSM-IV-TR MULTIAXIAL ASSESSMENT MUST BE COMPLETED

Axis I – Clinical Disorders

Axis II – Personality Disorders, Mental Retardation

Axis III – General Medical Conditions

Axis IV – Psychosocial and Environmental Problems

Axis V – Global Assessment of Functioning

Prior authorization request may be phoned, faxed or mailed into the call center (see below)

InfoCrossing
P.O. Box 4800
Jefferson City, MO 65102
Phone (toll free) 866-771-3350
Fax 573-635-6516

AN APPROVED AUTHORIZATION APPROVES ONLY THE MEDICAL NECESSITY OF THE SERVICE AND DOES NOT GUARANTEE PAYMENT.

MO 886-4140 (6-08)

10.3

PHARMACOLOGICAL MANAGEMENT - 90862
Participant Name: _____ Provider name: _____
Participant DCN: _____
Date of Visit: _____ Location/Setting:_____
Begin and End Time: _____
Current Diagnosis (should be updated annually, at a minimum): _____
_____
Prescribed and/or Continued Medications: Dose/Frequency:
_____
_____
_____
_____
_____
_____
Current Symptoms:
_____
_____
_____
Mental Status:
_____
_____
_____
Response to treatment/Side Effects:
_____
_____
_____
Medication Changes/Adjustments:
_____
_____
_____
Labs/Tests done or pending:
_____
_____
_____
Recommendations/Plan:
_____
_____
_____

Provider Signature _____ Date _____

NONDISCRIMINATION POLICY STATEMENT

The Missouri Department of Social Services (DSS) is committed to the principles of equal employment opportunity and equal access to services. Accordingly, DSS employees, applicants for employment, and contractors are to be treated equitably regardless of race, color, national origin, ancestry, genetic information, pregnancy, sex, sexual orientation, age, disability, religion, or veteran status.

All DSS contracts and vendor agreements shall contain nondiscrimination clauses as mandated by the **Governor's Executive Order 94**-3, Article XIII. Such clauses shall also contain assurances of compliance with Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Act of 1990 (ADA), as amended; the Age Discrimination Act of 1975, as amended and other pertinent civil rights laws and regulations.

DSS applicants for, or recipients of, services from DSS are to be treated equitably regardless of race, color, national origin, ancestry, sex, age, sexual orientation, disability, veteran status, or religion. Appropriate interpretive services will be provided as required for the visually or hearing impaired and for persons with language barriers. Applicants for, or recipients, of services from DSS who believe they have been denied a service or benefit may file a complaint by calling the DSS Office for Civil Rights at (800) 776-8014 (Toll Free); or Relay Missouri for hearing and speech impaired at (800) 735-2466 (Voice); (800) 735-2966 (Text). Complaints may also be filed by contacting the local office or by writing to:

> Missouri Department of Social Services
> Office for Civil Rights
> P. O. Box 1527
> Jefferson City, MO 65102-1527

Applicants for, or recipients of services from DSS who believe they have been denied a service or benefit because of race, color, national origin, sex, age, disability, or religion may also file a complaint by writing to:

> U.S. Department of Health and Human Services
> Office for Civil Rights
> 601 East 12th Street, Room 248
> Kansas City, MO 64106
> (816) 426-7277 (Voice); (816) 426-7065 (TDD)

Additionally, any person who believes they have been discriminated against because of race, color, national origin, age, sex, disability, religion, or political belief in any United States Department of Agriculture related activity (e.g. food stamps, commodity food, etc.) may write to the:

> U.S. Department of Agriculture
> Office of Adjudication and Noncompliance
> 1400 Independence Avenue, SW
> Washington, DC 20250-9410
> (866) 632-9992 (Voice); (800) 877-8339 (TDD); (800) 845-6136 (Spanish)

This policy shall be posted in a conspicuous place, accessible to all applicants for services, clients, employees, and applicants for employment, in all divisions, institutions and offices governed by DSS.

April 2013